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BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine Medigram

VOL. 77, NO. 1, JANUARY 13, 1978

CAPSULES

New physicians just starting to practice who would like to enroll in MSMS' February practice management seminars are urged to call MSMS headquarters soon. The seminars are limited to 27 persons and enrollments will fill quickly. Dates are Feb. 14-15 at the Hyatt Regency Dearborn, and Feb. 16-17 at Long's Convention Center, Lansing. The seminars are sponsored by MSMS and the AMA jointly, and are presented by professional management consultants. Interested physicians are urged to call John Richards at MSMS headquarters.

* * *

Blue Cross/Blue Shield of Michigan now is requiring all Michigan pharmacists to place Michigan physicians' DEA numbers on claims for prescriptions. The onus is on the pharmacist to get the physician's number on the form.

* * *

With the January issue, Michigan Medicine is beginning a year-long series of special sections of high interest to Michigan MDs. The first describes MSMS efforts to bring good Category I CME programs to physicians around the state. The February issue will present a status report on health care planning in Michigan. The third will describe MSMS research efforts re health care delivery on behalf of Michigan physicians.

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Films to educate patients are being studied by the MSMS Committee on Professional Liability. The committee, chaired by Robert M. Leitch, MD, Battle Creek, past MSMS president, would like to make such films available to Michigan physicians to help in obtaining

(continued)

MSMS leaders hopeful as Blues' negotiations continue

MSMS leaders are hopeful over progress of negotiations with Blue Cross/Blue Shield of Michigan re the Blues' new reimbursement policies. The MSMS Council Jan. 25 will receive a report of latest developments from the MSMS Negotiating Committee. The committee will describe the 11th hour Dec. 28 meeting of MSMS and BCBSM representatives. The meeting was held just before the new Blue Cross/Blue Shield policies were to go into effect and Michigan doctors said they would begin departicipation with the Blues, in protest. At that meeting, the highest priority problems were identified as the differential in Blues' payments to participating and non-participating physicians, and the need for a meaningful and workable cost savings plan.

MSMS members were advised in a Dec. 29 letter from MSMS President Bass of the new negotiations. Because of this, some members who are planning to departicipate are temporarily participating on a per-case basis, pending these negotiations. MSMS has learned that other doctors have elected to fully departicipate and bill patients directly.

Meanwhile, MSMS is pursuing in the courts the special concerns of Michigan otolaryngologists, ophthalmologists and psychiatrists.

Insurance commissioner asks MSMS for help with new Blues' legislation

At the request of the Michigan Insurance Commissioner, MSMS is offering advice and comment in the drafting of legislation which would change the structure of the Blue Cross/Blue Shield of Michigan Board. The Commissioner has declared his intention of writing legislation which would create a new board of subscribers and other public members, and would eliminate all physicians and other health care professionals from the board. MSMS comments and advice will be attempting to assure the proper medical input into the BCBSM board. Appointed to an MSMS task force to work with the commissioner are W. E. Maldonado, MD, chairman, MSMS Committee on State Legislation and Regulations, and Robert Burton, MD, Grand Rapids.

patients' informed consent. The committee will report Jan. 25 to the MSMS Council on a series of films prepared for the Colorado Medical Society.

* * *

Two seminars on the art of negotiations will be held in February and March by MSMS and the AMA. The seminars are scheduled Feb. 21-23 and March 28-30 at Long's Convention Center and the Hospitality Inn, both in Lansing, respectively. The seminars will offer 12 hours of Category I credit provided by the AMA. Further information is available from William Madigan at MSMS headquarters.

* * *

Two Michigan people have been chosen for the program of the AMA's 74th Congress on Medical Education Feb. 3-5 in Chicago. Robert B. Carbeck, MD, Ann Arbor, vice president of the Association for Hospital Medical Education, will preside for one session. Pamela M. Gurnick, MSU medical student, will represent the AMA Student Business Section on a panel.

Athletic medicine conference April 13

Team physicians, coaches, athletic trainers and others interested are invited to the 1978 MSMS Conference on the Medical Aspects of Organized Athletics April 13 at Long's Convention Center, Lansing. Edward M. Fugate, MD, Muskegon, is chairman of the planning committee. Further details will appear in future issues of Medigram and Michigan Medicine.

Physicians must complete new forms

Incorporated Michigan physicians are included for t
first time this year in U.S. Census Bureau questior
naires on business activities of their corporations
The questionnaires now being received by Michigan doctors are very extensive and law requires they be completed. Professionals previously have been excepted from having to fill out such forms. Further information is available from John Richards, MSMS headquarters.

MDPAC scheduling speakers

The Board of Directors of the Michigan Doctors Political Action Committee is actively promoting th
involvement of Michigan physicians in political affairs. Members of an MDPAC "Speakers Bureau," composed of MDPAC leaders, are addressing the general membership of component medical societies. Th
speaking schedule includes: Muskegon, Jan. 17, Robert Paxton, MD; Kent, Feb. 14, Robert Paxton, M
Ingham, Feb. 21, Louis Zako, MD; Jackson, Feb. 21,
Thomas Payne, MD; Macomb, Feb. 21, Frank Walker, M
Saginaw, Feb. 21, Charles Oppy, MD; Genesee, Mar.
Louis Zako, MD.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Managing Editor: Judith Marr

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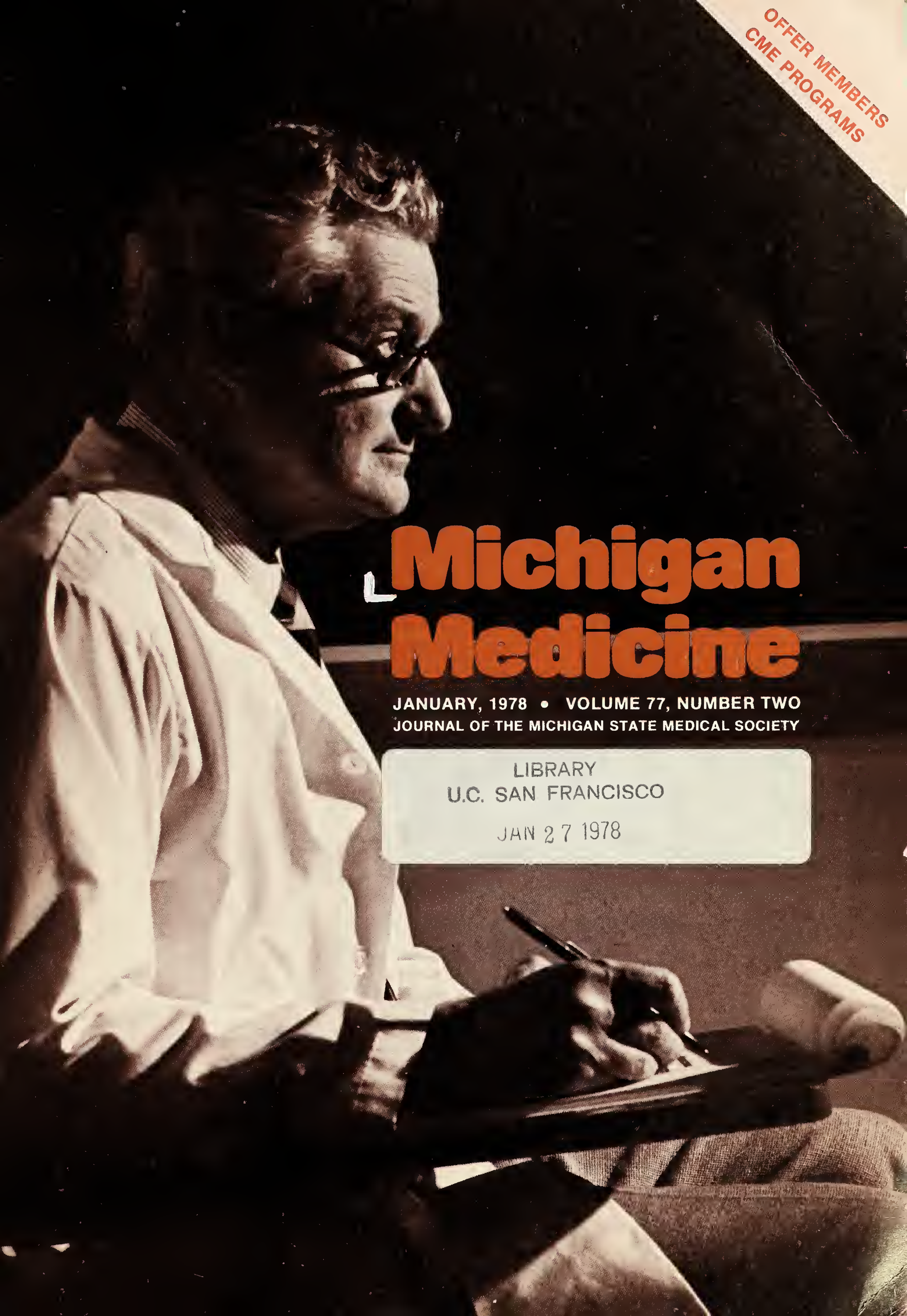

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CME PROGRAMS

Michigan Medicine

JANUARY, 1978 • VOLUME 77, NUMBER TWO
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CAPSULES/cont

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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Michigan physicians are back in the classroom. Special section pages 1-4 describes MSMS efforts to bring quality CME programs to MSMS members.

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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OFFER MEMBERS CME PROGRAMS

Scientific programs offered members by MSMS CME Programming Committee

The MSMS Committee for CME Programming was organized in 1975 to consolidate and coordinate all MSMS conferences and plans for postgraduate training. The new Committee built upon the good experiences of the planning committees for the Annual Scientific Meetings, the Annual Maternal Health Conferences, and other meetings and upon the strong record of service by the former MSMS Postgraduate Education Committee, led many years by Harry Towsley, MD, Ann Arbor.

The new Committee was formed to include — and still includes — (1) doctors who are hospital directors of medical education, (2) representatives of the three medical schools, (3) leaders of several specialty societies, and (4) interested doctors from rural and urban areas and from the various geographic regions. The Committee also has input from professional adult educators associated with medical organizations and state universities.

The Committee has a number of new members. The group is meeting every month to hear progress reports, to consider new ideas and thus accept responsibilities assigned by the MSMS House of Delegates and MSMS Council.

John G. Wiegenstein, MD, a past president and a founder of the American College of Emergency Physicians, was the first chairman of the CME Programming Committee. He led the Committee to develop good procedures and to establish effective coordinating processes. The Committee, after provisional status for one year, was accredited to sponsor Category I programs and to co-sponsor such activities with components, specialty societies and others.

Carl F. Hammerstrom, MD, of Marquette, was selected as chairman in early 1977 when Doctor Wiegenstein asked to be relieved of the heavy responsibilities. Doctor Hammerstrom, an internist, is in charge of coordinating the internal medicine training program in Marquette for the 20 medical students in the unique Upper Peninsula educational program operated by the MSU College of Human Medicine.

Herbert A. Auer is the staff assistant for the Committee and for all Michigan State Medical Society CME programs. A former teacher and newspaper editor, Mr. Auer was with the Michigan State University Continuing Education Service before joining MSMS. He holds a master's degree in adult education. A past president of the Michigan Adult Education Association, he continues as secretary of AEAM, the professional society in Michigan for adult education specialists.

The members of the MSMS Committee for CME Programming are:

Carl F. Hammerstrom, MD, Chairman, Marquette
Harvey M. Andre, MD, Grand Rapids
Robert E. Birk, MD, Grosse Pointe
Norman F. Bolton, MD, Detroit
Paul T. Chapman, MD, Grosse Pointe Park
Edward Cotton, MD, Marcellus
Frank Cox, Jr., MD, Detroit
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Carl M. Frye, MD, Ann Arbor
Jon C. Herbener, MD, Hillsdale
Rodman C. Jacobi, MD, East Lansing
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Richard B. Michelson, MD, Ann Arbor
Charles W. Shipman, MD, Traverse City
Yvan J. Silva, MD, Detroit
Lewis E. Simoni, MD, Flint
Daniel J. Wilhelm, MD, Port Huron
Robert F. Wilson, MD, Detroit
Anna Brown, PhD, Consultant, Ann Arbor
Andrew Kovacs, Consultant, Lansing
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Roger Mecum, Consultant, Detroit
Michael Nolen, Consultant, Lansing
Floyd Pennington, PhD, Consultant, Ann Arbor
Geoffrey Smith, Consultant, Allendale
Ray E. Yeater, Consultant, Ann Arbor

Dr. Wilson To Lead Plans For '78 Event

Formal planning for the MSMS annual scientific meeting has begun earlier each year. The first planning meeting for the 1978 Annual Scientific Meeting was held on Oct. 3, 1977 — one month before the 1977 meeting took place.

At that meeting a timetable was developed that will move up by several months the deadlines used for the recent meeting in Dearborn. Planners hope the preliminary program for the Nov. 7-9, 1978 meeting at the Detroit Plaza will be completed before summer so it can be sent to all MSMS members then. If doctors can know in June what subjects will be covered at the Annual Scientific Meeting courses, then they can plan their CME for the final six months of 1978.

Robert F. Wilson, MD, Detroit, has accepted appointment as program chairman for 1978 — his third consecutive year. He is eager to explore some new ideas for 1978 and to continue to seek ways to further improve the MSMS program, which is perhaps the most extensive state society program in the nation. The course-work approach from 1976 and 1977 will provide the solid foundation for 1978 plans.

See Page 2 — Scientific Meeting Recap
See Page 4 — Seminar on CME Instruction
See Page 4 — CME & Causes of Death
See Pages 26-27 — November Meeting Photos

345336

MSMS members enrolled in 55 Category I courses at the Dearborn Hyatt Regency during the three-day Annual Scientific Meeting. Many doctors said they attended because "certain topics interested me." See page 3 for more comments from the questionnaire used at the meeting.

9,500 hours of CME credit granted at Annual Session; 1,325 physicians enrolled

Michigan physicians attending the 1977 MSMS Annual Scientific Meeting, November 8-9-10 learned about "practical advances in patient management" (theme for the session), and also earned 9,600 hours of Category I Credit toward the AMA Physician's Recognition Award and the state requirements for recertification.

A total of 1,530 different physicians attended one or more courses. The advance registration this year totaled 881, with 144 walk-ins on Nov. 8, 215 on Nov. 9 and 86 on Nov. 10.

The physicians enrolled for a total of 3,200 seats in the 55 courses. Each physician earned an average of seven hours of Category I Credit by particiating in an average of 2.5 courses.

A total of 204 physicians served as course directors or instructors.

Among the 1,530 doctors who participated 128 were house officers and 41 were non-members.

The 1977 Scientific Meeting program was developed for the second consecutive year by Robert F. Wilson, MD, assistant dean of the Wayne State University School of Medicine, and his committee, all under the supervision of the MSMS Committee for CME Programming.

How were the plans developed?

Chairman Wilson directed the planning of the total program. As he explained the concept: "The overall theme was 'Practical Advances in Patient Management'." The emphasis was on the practical aspects of everyday patient care. We limited discussion of rare or exotic subjects, and focused on medical care problems that occur frequently. Whenever possible, the half-day courses also dealt with basic science information appropriate to the content to help the physician understand newer diagnostic and therapeutic measures.

Doctor Wilson is extremely appreciative of the "excellent cooperation given by Michigan doctors who served as course directors and who served on the 'faculty'." "We believe," Doctor Wilson explained, "that it is a privilege and obligation for Michigan physicians to share their knowledge, without charge, with other doctors in their own state at the major MSMS continuing education meeting."

Doctor Wilson continued: "As program chairman for the 1976 and 1977 Scientific Meetings and the coming 1978 meeting, I am stressing quality more than anything else. We want the world's best CME meeting right here in Michigan for Michigan doctors."

Some comparisons can be made between the 1976 and 1977 meetings, remembering that both of them constituted quite a change in programming from the meetings prior to 1976. There were nine more half-day courses offered in 1977 and the average attendance in each class was lower in 1977 because the registration totals were down several hundred. There had been some adverse comment in 1976 because several courses enrolled more than 200. By offering more courses in 1977, the peaks were leveled off so that only a few courses drew more than 100 doctors.

The 1977 Committee had anticipated a smaller enrollment because the element of newness of the Hyatt Regency would not be a drawing card as it was in 1976. There were several major conflicts in 1977 — such as a family practice program at Michigan State University, the national ACEP meeting in San Francisco and a major conflict in the surgery field.

The final financial report was not available as this article went to the printers.

Once again, the educational exhibits by pharmaceutical firms and others providing products and services for the medical profession helped to finance the big fall meeting. Representatives of 60 firms conferred with physicians about new concepts and products.

What did doctors say about the meeting?

Every doctor at the Annual Scientific Meeting was given a general CME questionnaire to complete. About 300 doctors turned in the form.

At a ratio of 16 to 10, the respondents said they did attend the 1976 Annual Scientific Meeting, also held at the Hyatt Regency in Dearborn.

The survey questionnaire asked "What factors convinced you to at-

"Thankful for range of courses"

Many physicians voiced their appreciation of the wide range of practical courses offered. One doctor, on an evaluation report, wrote, "Even if I am a psychiatrist, I still feel that doctors need to update themselves on medical topics."

Another doctor supported courses "that develop the psycho-socio-biologic model of medicine rather than the archaic biologic model."

"Many thanks for the 'no smoking' policy this year," wrote one doctor after the meeting. No objections were received during the three-day meeting because of the MSMS Committee for CME Programming decision to ban smoking during the courses. A 30-minute recess was provided in all courses for those who wanted coffee or a cigarette, or to make necessary phone calls.

Of the doctors completing the CME questionnaire, one of every two praised the Hyatt Regency Dearborn as "a good location." But, it was difficult to please everyone. One doctor wrote, "the location is very poor, I'll never drive into this mess again."

The 1978 Annual Scientific Meeting will be at the Detroit Plaza.

and the doctors could check one or more.

The replies were:

215	Certain topics interested me
167	Good location
146	Need for Category I Credit
139	Reasonable Cost
69	Specialty society was involved
38	Certain speakers interested me
17	Other reason
16	Need for AAFP prescribed credit

The questionnaire also asked the doctors to check one or more of the 21 disease classifications that "would interest you for further study at CME meetings."

The subject that was checked most often (120 times) was "endocrine, nutritional and metabolic diseases."

How was the project staffed?

Doctor Hammerstrom has been generous in praise of the MSMS staff. Letters had to be written, materials duplicated, facilities scheduled, etc. At the meeting, staff members handled the registrations and payment of fees, and others served as course assistants. The planning and staffing were under the direction of Wayne Burmeister for registrations and room arrangements and Herbert Auer for the CME programming.

Did the medical schools help?

A new element for the 1977 Annual Scientific Meeting was the active participation by 21 different units from the three Michigan medical schools. These 21 include 11 different departments and two other areas. The University of Michigan School of Public Health also cooperated in a close relationship with the Michigan Public Health Association and the Michigan Public Health Officers Association.

Many faculty members of the three medical schools served as course directors and instructors for the 55 courses.

What groups helped sponsor courses?

A total of 30 state specialty societies, MSMS sections and other medical organizations cooperated to present the half-day courses. This total is up seven from 1976, when 25 groups participated.

In addition to the many organizations that cooperated to develop half-day courses, there were three other specialty societies, three other sections, and the Wayne County Medical Society, which sponsored various lectures, business meetings and social events.

Members of the American Academy of Family Physicians had many opportunities to gain AAFP prescribed credits, as 46 of the 55 courses were approved by AAFP headquarters as being practical and valuable for family physicians.

30 specialty organizations helped MSMS

The MSMS leaders voice their sincere appreciation to the following for working with MSMS on Category I courses:

American Medical Women's Association, Blackwell Branch 20

Commission on Professional and Hospital Activities

Michigan Academy of Family Physicians

Michigan Academy of Physical Medicine and Rehabilitation

Michigan Academy of Plastic Surgeons

Michigan Allergy Society

Michigan Branch, American Urological Association

Michigan Chapter, American Academy of Pediatrics

Michigan Chapter, American College of Emergency Physicians

Michigan College of Nuclear Medicine Physicians

Michigan Department of Public Health

Michigan Dermatological Society

Michigan Occupational Medicine Association

Michigan Ophthalmological Society

Michigan Otolaryngological Society

Michigan Psychiatric Society

Michigan Psychoanalytic Society

Michigan Public Health Association

Michigan Public Health Officers Association

Michigan Society of Colon and Rectal Surgeons

Michigan Society of Internal Medicine

Michigan Society of Therapeutic Radiologists

Michigan Society of Thoracic Surgeons

MSMS Committee on Sports Medicine

National Foundation Ileitis and Colitis

MSMS Section of Clinical Pharmacology and Therapeutics

MSMS Section on Plastic Surgery

MSMS Section on Surgery

MSMS Section on Thoracic Surgery

Helping doctors To teach better

One of the current efforts of MSMS to improve the quality of CME in Michigan is to help doctors improve their skills as teachers of CME.

MSMS will conduct a second nine-hour Category I Seminar to Improve CME Instruction this spring at MSMS. Interested physicians may write the MSMS CME Programming Committee for seminar details.

The first seminar drew 18 registrants to MSMS Oct. 27-28 from Michigan communities as scattered as Petoskey, Detroit, Kalamazoo and Bay City. A registration fee was charged to cover the honoraria and materials.

A task force from the CME Programming Committee explored the needs for such a seminar and developed the course content with Stephen Yelon, PhD, MSU Learning and Evaluation Service.

Rodman Jacobi, MD, of the MSU Department of Family Practice, was chairman of the task force.

The subjects covered were needs assessment, development of educational objectives, use of alternatives to the lecture method and evaluation of experiences.

Asked to use a scale with six graded replies, all of the participants rated the seminar as "outstanding" or "very good" — the two highest responses.

When asked how the seminar was helpful, a large majority of participants indicated the seminar had "clarified and organized my thinking" and "given me new information."

In response to another questionnaire in the evaluation process, a large majority of doctors reported they "would share the ideas and skills gained with colleagues" and "would investigate further and think more about the ideas and skills."

Considerable interest has been shown by the AMA and several other state medical societies. MSMS is believed to be the first state medical society to develop and conduct a project of this nature.

How to impact CME on causes of death?

"MSMS could make considerable impact in preventive health care and improved medical care if MSMS could find ways to relate CME to the causes of death of Michigan residents," says Carl F. Hammerstrom, MD, chairman of the MSMS Committee for CME Programming.

"We want to consider possible courses and clinics that try to reduce homicides, suicides and accidents — the top three causes of death among our Michigan people who are under 55," he added. Public educational programs could tie in with CME plans, he points out.

While the major cause of death among all people is heart disease, with 29,233 in 1976, that cause claimed only 2,724 persons under 55 or only 9 percent.

Following are the statistics, prepared by the MSMS Department of Public Service, Communications and Physician Education, based on 1976 figures compiled and supplied by the Office of Vital and Health Statistics of the Michigan Department of Public Health:

Major Causes of Death in Michigan in 1976

CAUSE	TOTAL DEATHS	% OF TOTAL DEATHS	TOTAL DEATHS OVER AGE 55 Number & %		TOTAL DEATHS UNDER AGE 55 Number & %	
Heart	29,233	38.6%	26,509	91%	2,724	9%
Myacardial Infarctian					1,545	
Chranic Eschemic Heart Disease					723	
Symptomatic Heart Disease					154	
Malignant Neoplasms	14,880	19.6%	12,168	72%	2,712	18%
Trachea Branchas Lung					612	
Breast					368	
Large Intestine, except rectum					172	
Leukema (Lymphatic, Myeloid, Monocytic)					171	
Brain					137	
Cervix-Uterus					120	
Cerebrovascular	7,354	9.7%	6,819	93%	535	7%
Accident	3,912	5.2%	1,265	32%	2,647	68%
Motor Vehicle					1,624	
Influenza-Pneumonia	2,106	2.8%	1,832	87%	273	13%
Diabetes Mellitus	1,719	2.3%	1,548	90%	171	10%
Cirrhosis of Liver	1,486	2.0%	828	56%	658	44%
Arteriosclerosis	1,207	1.6%	1,198	99%	9	1%
Suicide	1,182	1.6%	316	27%	866	73%
Homicide	1,092	1.4%	146	14%	946	86%
Emphysema	759	1.0%	715	94%	44	6%

Prepared by MSMS Department of Physician Education-Communications-Public Service, based on information compiled and supplied by the Office of Vital and Health Statistics of the Michigan Department of Public Health.

Vernon V. Bass, MD
MSMS president

Michigan doctors' unity demonstrated in Blues protest

MSMS is not a paper tiger. We, the members, have proven that. The main theme of my inaugural address was that no one can injure the profession from without. Therefore, unity was my number one aim.

Almost immediately the issue of the Blues' new reimbursement programs, and disrespect for our patients through those programs, arose. The MSMS Committee on Negotiations recommended to the MSMS Council that MSMS members departicipate with such programs. The Council unanimously agreed and called the special House of Delegates meeting. The special House of Delegates meeting unanimously approved the resolution in five parts.

Many said doctors would not follow their leadership and were not as principled as I have always insisted. There were those who said we'd be generals who would turn to the troops and the troops would not be there.

The delegates, Council members and I began to inform our members. I had found the truth would beat the attempt of the Blues to make Michigan a giant HMO and put our citizens under economic medical control.

How wrong those detractors were!

The support was greater even than I had hoped.

Letters of support came from many groups.

Even the AMA passed a resolution against discrimination in reimbusement of non-participating physicians. It was supported by Indiana, New York, Ohio, Tennessee and Michigan, many other states' delegations and sections. In fact, no one disapproved. It passed unanimously.

We are united! Our patients suffer if third parties interfere with the doctor-patient relationship. The profession of medicine will not tolerate that, regardless of financial loss.

I've said it before — I'm proud of my profession and what it stands for. Thanks for your massive support.

The medical society is growing stronger. The few members who object are important. But those who in their ignorance do not belong should be brought into the fold. There is no good reason for not belonging to our county and state societies and to the AMA. And yes, our political action arm — MDPAC. The dues we pay are less than the union worker must pay.

I wish you health and prosperity for the new year.

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*Librax has been evaluated as possibly effective for this indication.
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Final classification of the less-than-effective indications requires further investigation.

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As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Letters

". . . another intrusion of profit-seeking companies . . ."

A new over-the-counter pregnancy test has now been made available to the public.

This represents another intrusion on the part of profit-seeking companies to practise medicine, and falls into the same category as the taking of blood pressures by automatic machines and non-medical personnel on street corners.

The dangers of self-diagnosis of pregnancy are numerous and obvious. False negatives and positives are realities that we all experience, and only careful and sometimes repeated pelvic examinations can determine an actual pregnancy. Contributing to the false diagnoses are proteinurea, tranquilizers, birth control pills and other gonadotrophins that exist in the blood and urine. A false positive test will send many frightened teenagers and menopausal women to seek abortions, only on the basis of this test, when in reality they were never pregnant! A false negative test can conceal a growing ectopic pregnancy that can rupture, with all its attendant complications.

It was a great disappointment to me to learn that this easily procured test is made available by an ethical drug firm, the Warner Chilcott Company.

I, for one, will stop prescribing any and all pharmaceuticals made by this drug firm; and I would encourage all other physicians to do likewise!

A. Lewis Hayes, MD
Franklin Medical Associates, PC
Southfield

". . . most pleased with the ad . . ."

Thank you for the November issue of *Michigan Medicine* and I want you to know that Michigan National Bank is most pleased with the ad as well as the program.

We look forward to a continued relationship with the Medical Society and have high hopes for the effectiveness of the advertising.

Robert T. Stanziano
Vice President
Michigan National Bank
Lansing

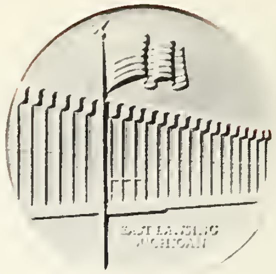
". . . most pleased by medical society . . ."

I thank you ever so much for intervening on my behalf with the Department of Social Services (on a Medicaid billing dispute) and obtaining a positive response from Mr. Dempsey. I really didn't think that the state government had compassion or would act favorably, but it was worth a try.

I must say that being one of the "Indians" in practice on this occasion as well as on several occasions in the past I have been most pleased by the courteous and effective response made by the State Medical Society in regards to my little problems.

I thank you.

Richard L. Taylor, MD
Adrian Radiological Associates, PC



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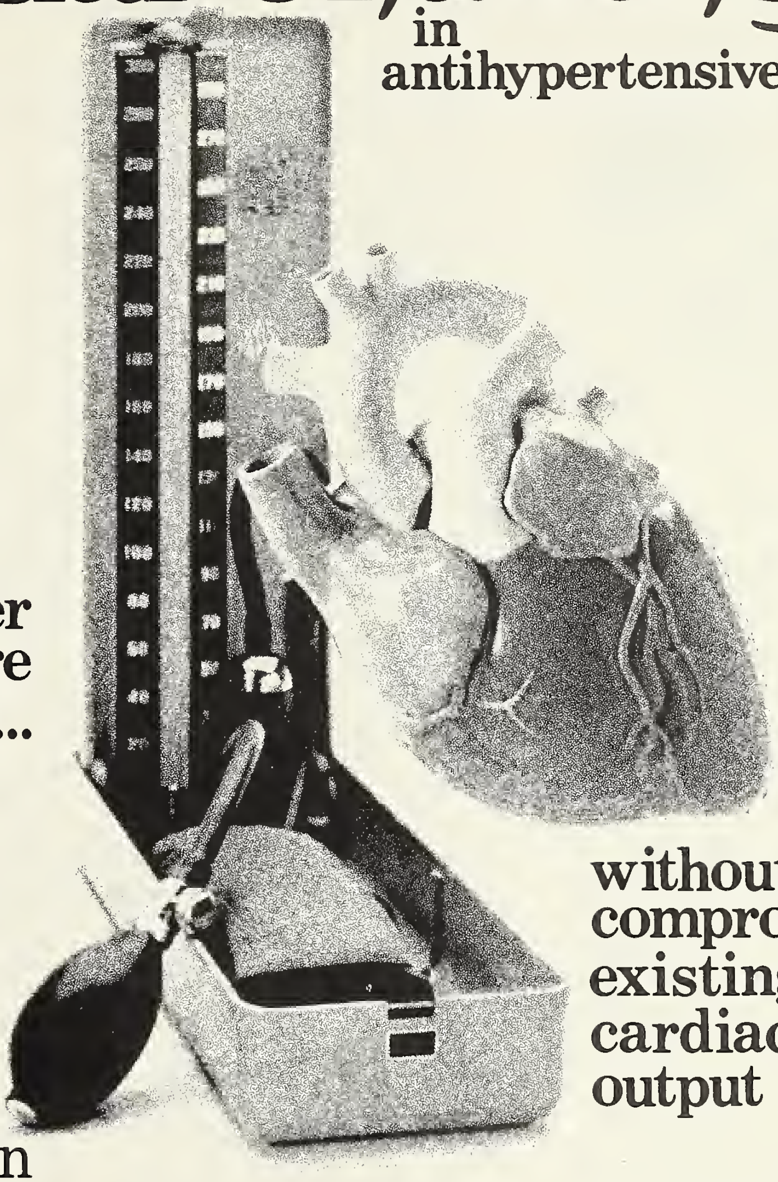

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For a brief summary of prescribing information, please see following page.

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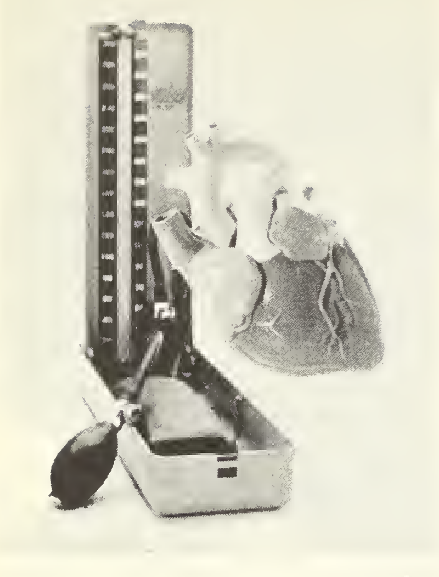

in hypertension

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blood pressure
effectively...
usually with no
direct effect on
cardiac function–
cardiac output is
usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information.
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Physicians should take the lead in patient education programs

By Donald J. Breckon, MPH, PhD, Mt. Pleasant

Hospital-based patient education programs are needed, are wanted, and are working. They are indeed an idea whose time has come.

It, therefore, is appropriate and timely for physicians to take the leadership in their hospitals and in their clinical practices and urge development of patient education programs. Now is the time to follow the lead of the AMA and be in the forefront of preventive medicine programming. Initiating, supporting, and extending patient education programs in hospital and clinical practices can meet some of the needs of physicians and patients. Such programs also can be the best public relations tools imaginable.

Patient education is not a new development but rather is as old as the doctor-patient relationship. As might be expected, some physicians have emphasized this more than others.

During the 1970's, however, patient education programming increased significantly, as patients demanded to know more about their problems than before.

Educational specialist needed

Yet it has become apparent through experience that not just anyone can design and conduct patient education activities. Doctors and nurses have technical training in health and illness, but virtually no training in education. Educational specialists can design and conduct educational programs, using the medical expertise of doctors and nurses as appropriate. Indeed, the team approach to patient education is stressed in the literature as being ideal. All most institutions need to do is add the educational specialist to complete the team.

What patient education can do

Evidence is building rapidly that patient education can make the following contributions to clinical practice:

1. Patient education has the potential to improve the prognosis of the patient. The patient's emotional well-being often demands answers to their questions, and information that they have not yet asked for.
2. Patient education has the potential to reduce malpractice suits. It has been established that the patient has a "right to know" in addition to his "need to know." Clearly, it is no longer permissible to quickly go through a consent form. Obtaining a signature is no longer enough.

   The scope of litigation in this area has dealt with informed consent per se, but also with the patient's right to information in his medical record, and his right to adequate self-care procedures upon discharge from the hospital. Clearly, there is much to commend a patient education program with the patient's progress written into the medical record.

   While informed consent is primarily the responsibility of the physician, there is some experience with delegating the informational part to a patient education program. The physician obviously would have reviewed and approved the material to be presented.

   The patient's right to know has also been emphasized in a "Patient's Bill of Rights," accepted by the American Hospital Association in 1972. Five of the twelve statements deal directly with the patient's right to know. While patient education won't resolve the malpractice issue, it has the potential to reduce such suits.
3. Patient education has the potential of improving compliance with physician orders. Many patients simply do not follow their doctor's orders. Much of the responsibility for this situation goes back to a lack of a complete understanding of what should be done and why. Most patients need full and thorough explanations of the procedures they are to follow, both verbally and in writing. Research does suggest that patient education programs do increase the rate of compliance.
4. Patient education has the potential to reduce the total health care costs per patient.
5. Patient education has the potential to improve patient attitudes toward health care systems.

The American Medical Association has strongly endorsed patient education programming in 1975, stating in a position paper, "There is a need indicated for a structured educational effort beyond that which individual members of the team can provide."

Models have been tested. Guidelines have been developed. Programs have been developed in 2,680 general hospitals. What remains to be done is to implement such programs on a widespread basis.

Doctor Breckon is associate professor of health education at Central Michigan University

Michigan Medicine welcomes commentary on current medical issues by MSMS members and others interested. Articles should not exceed 800 words, and should be mailed with duplicate copy and recent photo of the author. Please address views to Michigan Medicine, 120 W. Saginaw St., East Lansing, 48823.

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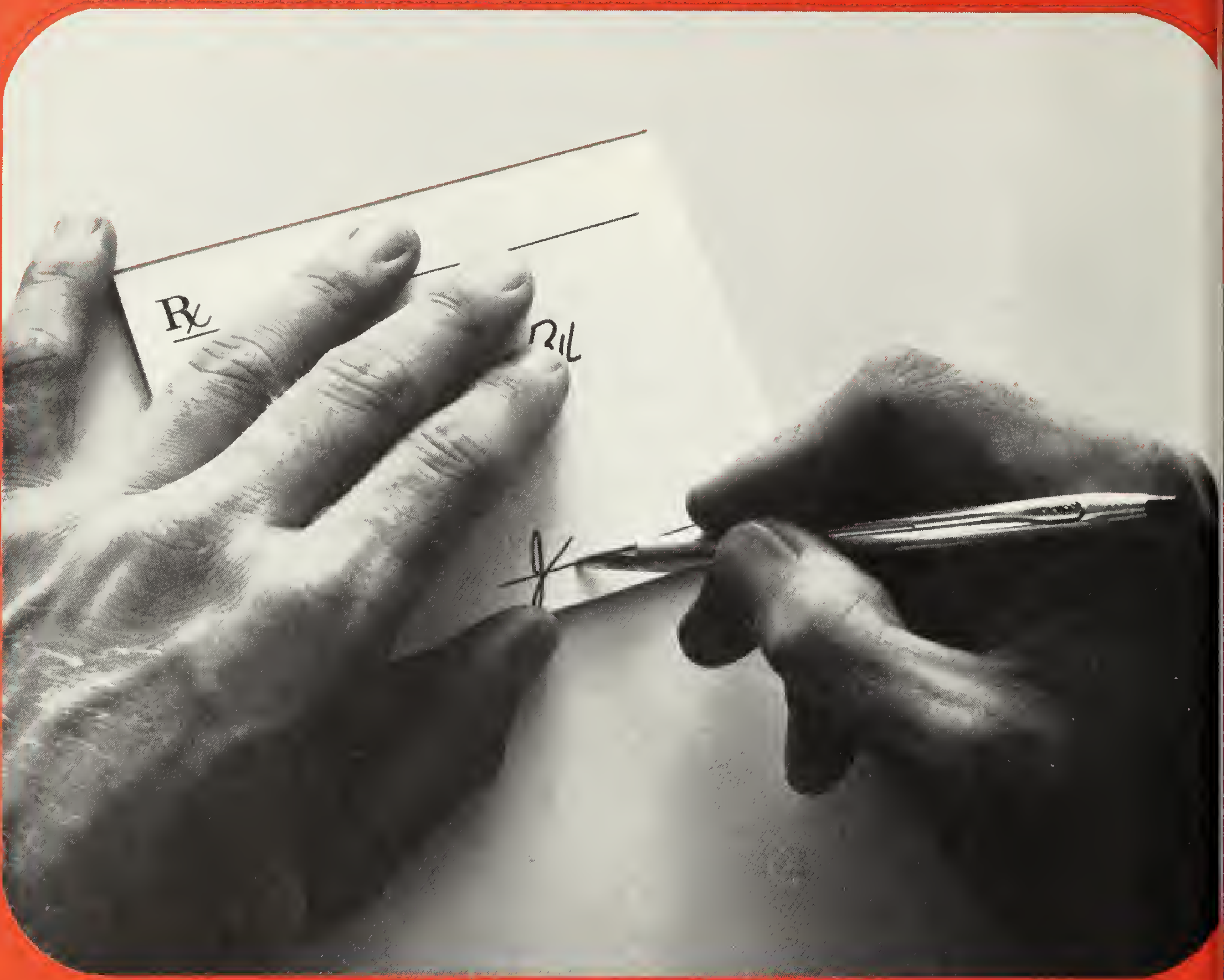


yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.

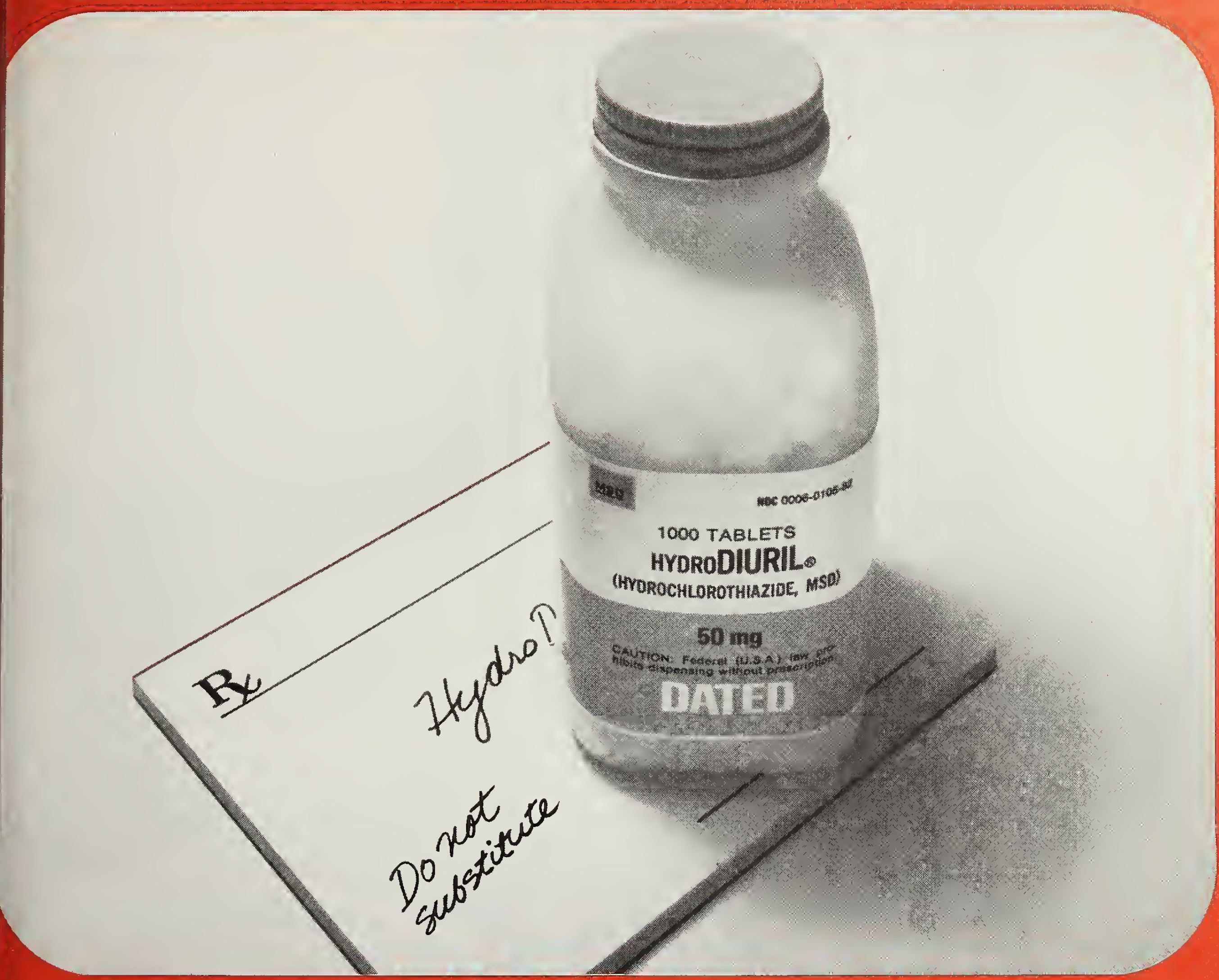
Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.

Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nause and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, o with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increase ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged, latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—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airment becomes evident, consider withholding or discontinuing iuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.

Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.

Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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Why psychiatrists question Blues programs for clinics

By Douglas A. Sargent, MD
Grosse Pointe Farms

Newspapers enthusiastically report the current controversy between the physicians of Michigan and BCBSM, highlighting the plight of the helpless "consumer" (formerly "patient") and often present the views of the Blues as facts. A recent article in the *Free Press* quoted a UAW Vice President (and director of BCBSM) to the effect that the "consumer's" rights were being safeguarded by the Blues against the depredations of greedy doctors.

Cost–containment

Yet we know that the other side — our side — of the controversy concerns the welfare of our patients too, and ought to be at least as interesting to the public as are the pious pronouncements of BCBSM spokesmen. The following excerpts from a protest made to the BCBSM Professional Practices Committee illustrates this point. Reacting to the BCBSM decision to eliminate long-term psychotherapy as a master medical benefit, the Michigan Psychiatric Society presented its views about ways to contain costs and to insure quality care. What follows is the section dealing with outpatient psychiatric services:

Since the inception of the Outpatient Psychiatric Clinic (OPCC) program, the Michigan Psychiatric Society has pointed out the cost of the OPPC program would be greatly reduced if claims were paid only for services rendered by, or under the close supervision of, a licensed physician qualified in psychiatry. Until now, BCBSM appears to have ignored our repeated warnings that Blue Cross providers who were in our opinion unqualified to diagnose or treat mental disorders were being paid for substandard services.

We notified BCBSM that we believed some members of our Society, too, were conniving at this raid on the medical dollar, and, if BCBSM would give us the necessary information, we would take action against them. Our request was turned down. We were no more successful when we protested the lack of appropriate standards to assure each patient would be competently diagnosed and proper treatment prescribed and supervised by a qualified psychiatrist. Now, almost two years later, it appears that these warnings and recommendations have gone unheeded.

Instead, functionaries from BCBSM have encouraged nonmedical persons to open "Blue Cross Clinics" all over the state. Lured by the promise of quick money and minimal controls, would-be clinic directors flocked to sign up as instant "providers." Entrepreneurs hired pliant physicians to rubber-stamp shoddy practices, sign Blue Cross claims and lend a spurious aura of medical respectability to this consumer rip-off. One notorious member of our own Society, by diligent effort, appeared to have ingratiated himself with the hierarchy and in one year felt bold enough to submit claims for more than $700,000! This alarmed BCBSM, and rightly so; MPS was not surprised.

When a respected officer of our Society asked for guidance from BCBSM in establishing an OPPC, he was told to get advice from this same notorious "provider," whose clinic BCBSM considered to be a model worthy of emulation. Today this policy, which dilutes and weakens the psychiatric leadership of OPPCs, continues unabated.

BCBSM's last-minute attempts to head-off financial disaster by multiplying the administrative paperwork required of OPPCs have had a paradoxical effect: instead of cutting costs, they have increased the cost of providing service while diverting valuable energies away from clinical work to the mindless production of documents interesting only to auditors.

Rather than contain costs, these peculiar policies have been accompanied by runaway costs. Today claims are running 10 to 15 times the income from premiums.

Standard of care

The OPPC program was launched in the bright hope that by following the pattern successful in the child guidance clinics, where a psychiatrist directed a "mental health team" of psychologists and social workers, outpatient care of high quality might be made widely available at a reasonable cost, and scarce psychiatric services could be more effectively utilized.

Central to this concept was the hope that, by thus amplifying scarce out-of-hospital resources, patients could be treated while continuing to function in the community.

When more costly hospital treatment was unavoidable, at least the availability of competent out-patient follow-up care might make it feasible to shorten hospital stay.

On this rational and apparently medically sound basis the OPPC program was endorsed and widely supported by the Michigan Psychiatric Society. Many of our members joined the program; many now feel that they have been "had."

Despite these conflicts, our members continue to carry the medical responsiblity for all patients in the OPPC program. BCBSM policies do not give the physician sufficient authority, however, to carry out this medical duty. Thus, in addition to failing at cost-containment, BCBSM policies do nothing to assure that subscribers get quality medical care.

Recommendations

MPS has proposed, on behalf of the patients whose welfare MPS and BCBSM seek, we enter into a covenant which has as its main purpose the provision of quality psychiatric services, and as its prime fringe benefit the containment of costs without sacrificing the health of subscribers. The main points such a covenant ought to contain are:

1) Assure the *clinical* quality of psychiatric services by adopting the standards for outpatient psychiatric clinics of the Joint Commission on Accreditation of Hospitals (JCAH) leaving to BCBSM the task of auditing and overseeing the *financial* operations of the OPPC. This will place in competent medical hands the confidential medical record, relieving BCBSM of this sensitive aspect of its managerial function (which in any case, BCBSM undertook only with great trepidation). OPPCs would be required to qualify for accreditation by the JCAH within a specified length of time or be dropped from the OPPC program.

2) BCBSM would pay only for outpatient psychiatric services that are provided by qualified medical practitioners or JCAH - approved OPPCs.

3) BCBSM would furnish the MPS with the names of clinics or of MPS members believed to be engaged in substandard practices or unethical conduct, together with the necessary actuarial and other data, so that MPS could investigate and proceed against those who are found to be in violation of the relevant standards of practice. An appropriate and effective investigative structure would be jointly established by MPS and BCBSM. (In time, other third-party-payors may be invited to support and participate in this function.)

4) Services provided by individual providers and OPPCs will be subject to ongoing peer-review, according to a scheme to be established jointly by MPS and BCBSM, based on appropriate, nationally-accepted standards (such as those of the JCAH).

Doctor Sargent

5) Prior-approval for psychiatric services deemed unusual or especially costly will be provided through a scheme similar to that established for peer review.

6) In order to anticipate and avoid damaging conflicts in future, MPS will, upon request, provide BCBSM with ongoing professional consultation and advice about the operation of the OPPC program.

7) If it does not already do so, BCBSM will withhold payments from public clinics for those services (or components) which already are subsidized by public funds and for which receipt of additional BCBSM payments might be considered to be "double recovery."

8) BCBSM will scrutinize such public agencies with special care to assure that services provided are clearly within the definition of medical services and provided according to JCAH standards, withholding funds from substandard or non-psychiatric services.

9) BCBSM will refrain from any advertising and sales practices which would tend to encourage attempts to provide subscribers with substandard or non-medical services under the guise of "Blue Cross-Approved" psychiatric services.

10) BCBSM will refrain from any activities which might tend to persuade subscribers to purchase insurance contracts with diminished or nonexistent psychiatric benefits. BCBSM will specifically avoid sales techniques which tend to create in the consumer the mistaken belief that the contract provides more extensive psychiatric coverage than is really the case. And as our efforts to come to an understanding with BCBSM failed the only course left was to sue; a course which we reluctantly took. ◥

Doctor Sargent is vice president, Michigan Psychiatric Society.

MDs need to identify, correct problems with patients

By Susan Adelman, MD
Detroit

In his recent presidential speech to the American College of Surgeons, Doctor Stinchfield called for unity in the face of the current public criticism of physicians and surgeons. He stressed the need to combat the recent accusations that large numbers of unnecessary operations are being performed, and he emphasized the importance of negotiating as a group with government regulatory agencies. He further reminded us that the more the surgical specialties bicker among themselves the more alone they each will stand, and the more vulnerable they each will be to critics and to detractors. There is much truth in what he said.

Something bothers me

On further consideration of his comments, however; something bothers me. This is the same thing that has bothered me in the past at medical meetings where my colleagues have discussed ways to improve our public image and to counteract an unfavorable press. The emphasis always seems to fall on publicizing our strong points, our concern for our patients and our many important modern medical advances. What disturbs me is that our public relations efforts seem to all be in our own behalf, and in a sense they call for sympathy and perhaps applause from our patients. Since we are widely perceived as making more money than our patients, appeals for sympathy are apt to fall upon deaf ears, and since the public seems to be angry with us for some reason, the applause is not forthcoming.

Doctor Adelman

More to the point, I think we are neglecting our most important homework, that of identifying those aspects of our behavior which are arousing our patients' ire and then doing something about them. Somehow our patients are emerging from their contacts with us feeling hurt and insulted. I am not sure that I know all the reasons why, but friends and relatives do tell me they are offended when they have to wait a long time in a doctor's office, when they see the doctor only for a minute or two at a time, when they are talked down to, or when they are made to feel they or their questions are stupid. They are frustrated when the doctor explains things to them in words they do not understand, exasperated when seemingly endless tests and X-rays are ordered. They tell me they feel cheated when more expensive medicines are prescribed when less expensive ones appear to be available.

This is quite a list of sins. Certainly very few of us commit all of these sins, but I do suspect that very few of us commit none of them. Knowing as we do that people are the most influenced by words and actions which affect them personally and directly, we might well wonder whether the reporter who has just written an article about unnecessary surgery has just been given a quick brushoff by his own doctor. It does seem logical to assume that we would most effectively combat our critics if we concentrated on making certain they do not feel personally affronted in their own contacts with doctors. We could set up committees and plan publicity campaigns, but it might be much more to the point if we found all of the doctors who the reporter in question had recently visited and had a little talk with them.

We need help, too

Unfortunately, the problems that I have mentioned above are the very ones most difficult for busy practitioners to correct. Perhaps what we physicians actually need is help, help in rearranging our appointment schedules, help from our nurses and receptionists in interpreting our instructions and explanations to our patients, help from our pharmacist colleagues with up-to-date price comparison information on medications, help from caring people in our office staff in facilitating arrangements for tests and in arranging subsequent appointments for the frightened and confused patient.

We might do well to investigate the idea of holding educational seminars on how to correct some of these problems. Even better, we as a profession might consider hiring market research analysts as do newspapers and industrial concerns to aid us in identifying the most pressing problems which annoy our patients and in supplying solutions for them.

Or, perhaps each of us should simply pick up the telephone now and without identifying ourselves as doctors, make an appointment with a physician, preferably a specialist, wait in the appropriate office for the appointment, obtain the tests and medications required, ask the specialist typical layman's questions, hear the way the answers sound and thus obtain a short course on how to best serve our patients, and, incidentally, ourselves. ◥

Doctor Adelman is a pediatric surgeon in private practice.

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Most Widely Prescribed—Antivert is the most widely pre-ribed agent for the management of vertigo* associated with seases affecting the vestibular system such as Menière's disease, byrinthitis, and vestibular neuronitis.

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Dosage for Vertigo*—The usual adult dosage for Antivert/25 one tablet t.i.d.

IEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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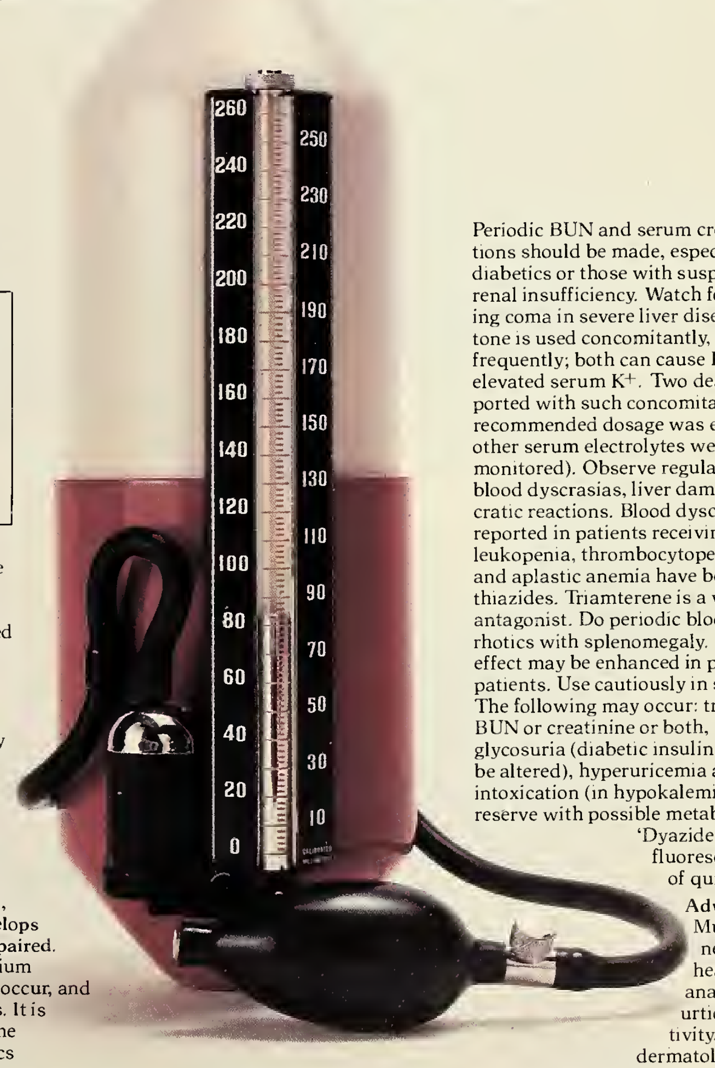

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated **widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION:* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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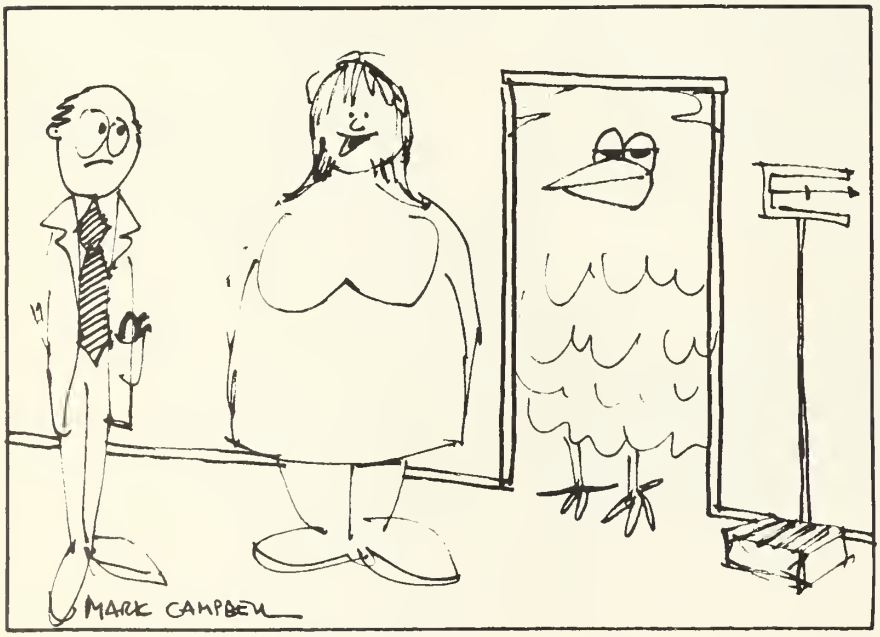

"But doctor, I only eat like a bird."

Stepping down estrogen levels to 50 mcg?

Ortho-Novum 1/50 ☐ 21 and 28 day

TRADEMARK

Each tablet contains 1 mg norethindrone and 0.05 mg mestranol. Each green tablet in the 28-day regimen contains inert ingredients.

a step in the right direction

See the complete prescribing information for this product, a summary of which is on the next page.

OJ 357-7

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Ortho-Novum 1/50

TRADEMARK

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IMPORTANT NOTE—This information is a BRIEF SUMMARY of the complete prescribing information provided with the product and therefore should not be used as the sole basis for prescribing the product. This summary was prepared by deleting from the complete prescribing information certain text, tables, and references where indicated by the symbol [ ]. The physician should be thoroughly familiar with the complete prescribing information and patient information before prescribing the product. [ ].

INDICATION: Contraception [ ]

CONTRAINDICATIONS: Oral contraceptives (OC's) should not be used in women with any of the following conditions.

1 Thrombophlebitis, thromboembolic disorders or conditions which predispose to these disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders 3 Cerebral vascular or coronary artery disease 4. Known or suspected carcinoma of the breast 5. Known or suspected estrogen-dependent neoplasia 6. Undiagnosed, abnormal genital bleeding 7 Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS:

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic These studies estimate that users of oral contraceptives are 4 to 11 times more likely to develop these diseases without evident cause than are nonusers Overall excess mortality due to pulmonary embolism or stroke is on the order of 1 0 to 3 5 deaths annually per 100,000 users and increases with age In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2 0 times greater in users than in nonusers and the risk of thrombotic stroke was 4 to 9.5 times greater in users than in nonusers. [ ]

An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported, confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not Oral contraceptives, however, were found to be a clear additional risk factor The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group [ ]

In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved This finding has been confirmed in the United States. Cases of thromboembolic disease have been reported in women using progestin-only oral contraceptives, and they should not be presumed to be free of excess risk

The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age Oral contraceptives are, however, an independent risk factor for these events [ ]

The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception The estimates of risk of death for each method include the combined risk of the contraceptive method (e g , thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method [ ] The study concluded that the mortality associated with all methods of birth control is low compared to the risk of childbirth, with the exception of oral contraceptives in women over 40, and that the lowest mortality is associated with the condom or diaphragm backed up by early abortion

The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors The use of oral contraceptives in women in this age group is not recommended

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e g , thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis) Should any of these occur or be suspected, the drug should be discontinued immediately

A four- to six-fold increased risk of post-surgery thromboembolic complications has been reported in oral contraceptive users. It feasible, oral contraceptives should be discontinued at least four weeks before surgery. [ ]

2 OCULAR LESIONS There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; sudden onset of proptosis or diplopia, papilledema, or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures

3. CARCINOMA Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. [ ]

In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives [ ]

One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in subgroups of oral contraceptive users with documented benign breast disease A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented

In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception

4 HEPATIC ADENOMA Benign hepatic adenomas appear to be associated with the use of oral contraceptives. Although benign, and rare, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage This has been reported in short-term as well as long-term users of oral contraceptives, although one study relates risk with duration of use of the contraceptive While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives [ ]

5 USE IN PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare This risk has been estimated as not greater than 4 per 1,000 exposures Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes

Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case control study has estimated a 4 7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion) Some of these exposures were very short and involved only a few days of treatment The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births

In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestins are effective for these uses.

There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives Embryos with these anomalies are virtually always aborted spontaneously Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown.

Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate torm of contraception for a period of time before attempting to conceive. Many clinicians recommend 3 months

The administration of progestin-only or progestin-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy

6. GALLBLADDER DISEASE. Studies report a doubling of the risk of surgically confirmed gallbladder disease in users of oral contraceptives or estrogen for 2 or more years

7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives

An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives.

8. ELEVATED BLOOD PRESSURE An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year Age is also strongly correlated with the development of hypertension in oral contraceptive users Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives

9 HEADACHE The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause

10 BLEEDING IRREGULARITIES Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy [ ] Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease

Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods

11 ECTOPIC PREGNANCY Ectopic as well as intrauterine pregnancy may occur in contraceptive failures However, in oral contraceptive failures, the ratio of ectopic to intrauterine pregnancies is higher than in women who are not receiving oral contraceptives, since the drugs are more effective in preventing intrauterine than ectopic pregnancies [ ]

12 BREAST FEEDING Oral contraceptives given in the postpartum period interfere with lactation. There may be a decrease in the quantity and quality of the breast milk Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs [ ] If feasible, the use of oral contraceptives should be deferred until the infant has been weaned

PRECAUTIONS: General 1 A complete medical and family history should be taken prior to the initiation of oral contraceptives The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests As a general rule, oral contraceptives should not be prescribed for longer than 1 year without another physical examination being performed 2 Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size 3 Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree Patients becoming significantly depressed while taking oral contraceptives should stop the medication 4 Oral contraceptives may cause some degree of fluid retention They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy If jaundice develops in any patient receiving such drugs, the medication should be discontinued 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients 7 Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency 8. Serum folate levels may be depressed by oral contraceptive therapy Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency 9 The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted 10 Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives

a Increased sulfobromophthalein retention

b Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3, increased norepinephrine-induced platelet aggregability

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered

d Decreased pregnanediol excretion.

e Reduced response to metyrapone test

INFORMATION FOR THE PATIENT (See Patient Package Insert)

DRUG INTERACTIONS: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with rifampin A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. [ ]

ADVERSE REACTIONS: An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS):

Thrombophlebitis, pulmonary embolism; coronary thrombosis, cerebral thrombosis, cerebral hemorrhage, hypertension, gallbladder disease, congenital anomalies

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed:

Mesenteric thrombosis, benign hepatomas, neuro-ocular lesions, e.g , retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related

Nausea, usually the most common adverse experience, vomiting reaction, occurring in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally, gastrointestinal symptoms (such as abdominal cramps and bloating); breakthrough bleeding, spotting; change in menstrual flow, dysmenorrhea, amenorrhea during and after treatment, temporary infertility after discontinuance of treatment, edema, chloasma or melasma which may persist, breast changes tenderness, enlargement and secretion, change in weight (increase or decrease), change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice, migraine, increase in size of uterine leiomyomata, rash (allergic), mental depression; reduced tolerance to carbohydrates, vaginal candidiasis

The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted:

Premenstrual-like syndrome; intolerance to contact lenses, change in corneal curvature (steepening), cataracts, changes in libido; chorea, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum; hemorrhagic eruption, vaginitis, porphyria, impaired renal function.

ACUTE OVERDOSE: Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children Overdosage may cause nausea, and withdrawal bleeding may occur in females [ ]

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Toxic Chemicals must be considered when patients present with symptoms

By C. R. Shelton
Special to **Michigan Medicine**

All physicians should take careful histories of their patients because the profession probably will see more and more people with chemical illnesses. And only by careful observation and long-term, complete histories will physicians know whether this is a major health problem or not.

That was the message brought to Michigan physicians by William B. Weil, MD, East Lansing during the recent MSMS Annual Scientific meeting Nov. 8-10 at the Hyatt Regency Dearborn.

Doctor Weil was one of the speakers in the course on "Environmental Chemicals in Office Practice." Course director was John L. Isbister, MD, Lansing, Disease Control Officer, Michigan Department of Public Health.

PBB the topic

Much of the Tuesday afternoon course was devoted to medical concerns about the possible significance of the chemical contaminant PBB, on maternal and child health.

Doctor Weil, chairman, Department of Human Development, Michigan State University, talked on "Clinical Observations on Infants Exposed to PBB in Utero," and "PBB in Breast Milk." He described a study involving 33 Michigan children, aged two to five, who were conceived before, during, or just after the farms on which their parents lived had been contaminated with PBB, and before this contamination was discovered and removed.

The study included 20 other children in the same age group, as controls, who were born outside of Michigan and did not live in the state until 1975, or those whose mothers were free of PBB.

Both groups of children were very much alike, according to records, at birth. Their developmental histories showed that they remained quite similar, however, the exposed group did develop slightly ahead of the controls.

Because of ethical considerations, many tests could not be made on the children, Doctor Weil noted. They did receive psychological testing, neurological studies, and complete physical examinations. Also, detailed, careful histories were taken, and PBB levels in the children's mothers were determined.

Doctor Weil concluded that at the time of the study — during the ages when it is believed the children would be most sensitive to PBB exposure — the exposed children did not significantly differ from the non-exposed group.

He emphasized that the above is *all* that the study showed, and would not hazard an opinion as to what would happen to the exposed children in the future.

Robert Nixon, MD, head, second medical division, Henry Ford Hospital, described studies on 23 patients with known significant PBB exposure. Those patients were subjected to identical protocols at the University of Michigan Hospital in Ann Arbor and at Henry Ford.

Doctor Nixon stated that each of the six patients that he personally examined have hepatomegalia.

"Does this, admittedly meager evidence, of hepatic involvement possi-

(Continued on page 28)

State's studies show no pattern of immunological problems due to PBB

The Michigan Department of Public Health has reported Michigan researchers have not so far found any significant pattern of immunological problems in a study of lymphocytes in 105 individuals enrolled in the Department's long term PBB study.

"The preliminary analyses of the lymphocyte tests seem encouraging," said Kenneth Wilcox, MD, Chief of the Health Department's Bureau of Disease Control and Laboratory Services. "Most analyses showed no significant difference between the people with high levels of PBB and those people with low levels of PBB. Those analyses that showed a difference between the groups revealed a somewhat better lymphocyte function for the high group than for the low group. This observation will not eliminate the need for additional retesting.

"The purpose of the study is to examine a group of 105 individuals enrolled in the Department's long-term PBB study who had different levels of PBB," said Dr. Wilcox, "and to evaluate their immune systems, specifically lymphocytes, a kind of white blood cell, which helps fight infection."

Wayne State University plastic surgery resident Satish C. Vyas, MD, serves as a model in discussion of the course on flap surgery. Course Director Neal R. Wilson, MD, Detroit, observes as instructor John McCraw, MD, associate professor of plastic surgery, Eastern Virginia Medical School, describes a technique.

Scenes of 1977 MSMS Scientific Meeting

The chance to meet with instructors was a feature during beer busts every day following the afternoon sessions.

Marvin H. Romsdahl, MD, Houston, Tex., takes a moment in the faculty headquarters to organize a slide presentation. Doctor Romsdahl participated in the session on "Radiation Therapy in Management of Breast and Colorectal Cancer."

Chester A. Bogucki, MD, Birmingham, earns CME credits in the popular Media Library center established for the Scientific Meeting by the University of Michigan.

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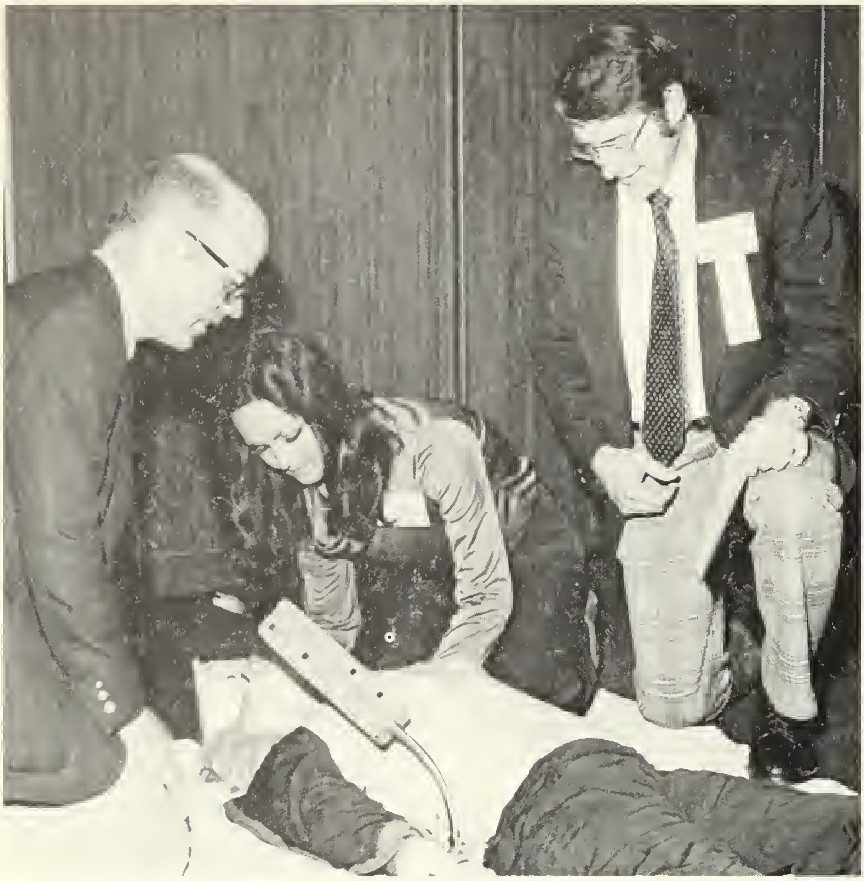
Y ACCREDITED BY STATE
FEDERAL GOVERNME

An exhibitor, Advance Medical and Research Center of Pontiac, took blood samples for physicians who wanted to be tested for lipid phenotypes.



The first sessions to fill during the Scientific Meeting were those on advanced and basic life support. At left, an MD prepares to learn cardiopulmonary resuscitation techniques with attendant. Observing is MSMS Annual Scientific Meeting chairman Robert F. Wilson, MD, Detroit.

PBB/*continued*

bly explain such frequent symptoms in PBB-associated illness as fatigue and loss of strength?" he asked.

Summarizing the studies, Doctor Nixon stated that the University examiners feel that the data derived from psychiatric evaluations of that group of patients strongly suggests an underlying organic brain syndrome. Doctors at Henry Ford Hospital believe those patients are more likely ill on the basis of hepatotoxicity.

David Axelrod, MD, director, Division of Laboratories and Research, New York State Health Department, urged physicians — specifically pediatricians and obstetricians — when talking with mothers to consider and be aware of the multiplicity of contaminants in maternal milk and the potential risk associated with nursing.

Physicians must be alert

Philip Landrigan, MD, chief, Special Studies Branch, Chronic Diseases Division Bureau of Epidemiology, National Center for Disease Control, Atlanta, stated that there is nothing mysterious about chemical illnesses, that they are another form of illness to which physicians must be alert.

However, if a doctor does not think of chemical illness when examining a patient, the diagnosis will seldom be correct because there are very few instances when signs, symptoms, and laboratory tests will specifically point to chemical illness.

"We must be alert and ask the right questions," Doctor Landrigan stressed. "In chemical illnesses, a patient's history is much more important than the physical examination."

"The history will tell what the patient is exposed to on the job, in the home, on the farm, or while working at a hobby. It also may give clues to exposure from chemicals in the air, in something that is eaten, or by some other means.

"Only when physicians have a complete history can we expect the toxicology laboratory to do much to narrow down differences in the causes of chemical illnesses, because there are thousands of chemicals all around us." ◥

New Wayne, U-M clinics aid pain victims, elderly

The new Levin Pain Clinic is in full operation at Wayne State University School of Medicine. It deals with the problems of chronic pain through various approaches. Patients will be treated by a team including an anesthesiologist, physical therapist, internist, psychologist, psychiatrist and other specialists. Robert En Ming Ho, MD, director of the clinic, has indicated that patients are to be accepted only on a referral basis.

Patients referred to the Pain Clinic will be seen and evaluated, and a course of therapy will be recommended. They will then be returned to the referring physicians with a letter detailing the findings and recommendations of the clinic. At the request of the patient's physician, therapy may be instituted within the Detroit Medical Center Hospitals.

* * *

A clinic designed specifically to meet the total health care needs of the senior citizens has opened at the U-M Medical Center. The Turner Memorial Clinic is located adjacent to the University Hospital's Parkview facility.

Its opening represents the first phase of a new comprehensive geriatric program at the U-M. The services offered at the Turner Clinic emphasize prevention and maintenance as an alternative to more costly institutionalization or hospitalization.

Clinic director is Ivan Duff, MD, a rheumatologist with special interest in geriatrics. He heads a team trained in health problems of the elderly.

“Changing Concepts . . .”

The 1978 Michigan Conference on Maternal and Perinatal Health

March 8-9
Hyatt Regency Dearborn

Presented by the Michigan State Medical Society, Michigan Section, Nurses Association, ACOG, District V, and Perinatal Association of Michigan

Program

Wednesday morning, March 8

Maternal transport
Neonatal intensive care outcomes
Team approach to infant transport

Wednesday afternoon, March 8

Growth patterns
Diseases of pregnancy
PIH
Debate: “Mechanisms for,
or implications for Therapy”

Thursday morning, March 9

Perinatal dilemmas
In-hospital birthing centers
Bonding

Thursday afternoon, March 9

Fetal Alcohol Syndrome
Diabetes
Diet

Chairman of the Maternal and Perinatal Health Conference is Bruce A. Work, Jr., MD, Ann Arbor, associate professor, Department of Obstetrics and Gynecology, University of Michigan Medical School. Information about registration and reservations may be obtained from Herb Auer at MSMS headquarters.

The conference is open to physicians, nurses, medical students and others interested. It annually attracts approximately 1,000 persons and is one of the most successful and popular of MSMS continuing education programs.

Even brilliant surgery can be complicated by infection...

ANCEF® is effective in post-surgical infections*

- *Broad coverage of the major areas of post-surgical infection due to susceptible organisms. See Indications on next page.

- High Levels Present in Tissues and Fluids†
Ancef® achieves high concentrations in bone, synovial fluid, skin and soft tissues (such as pleural fluid, peritoneal fluid and lymph nodes). Ancef® is also excreted in a microbiologically active form in urine.

- High and Prolonged Serum Levels
A single 1 gram IV injection produced a mean peak concentration of Ancef® of 190 mcg/ml in healthy adult volunteers. After 4 hours, levels of 16.5 mcg/ml were still present.

- IM or IV Dosage Flexibility
The same dosage schedule can be used for both IM and IV administration.

- Well Tolerated
Most frequently reported adverse reaction is pain on injection. Please see next page for a complete list of reported adverse reactions. **Use with caution in patients with penicillin or other allergies.**

Please see next page for a brief summary of prescribing information, including indications, contraindications, warnings, precautions, and adverse reactions.

†Data on file, SK&F Medical Department. Tissue penetration is regarded as essential to therapeutic efficacy, but specific antibiotic tissue levels have not been directly correlated with specific therapeutic effects.

Smith Kline &French Laboratories
Philadelphia, Pa.

ANCEF® IV/IM
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)

Injection: 250 mg, 500 mg, and 1 gram vials

SK&F
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ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg, 500 mg, and 1 gram vials

Most infections can be treated with 500 mg. or 1 gram of 'Ancef' every 8 hours.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

Respiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus.*

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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SK&F
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Country Doc's Notebook

Physicians must restore that out-of-fashion word

By Norton Cooksey, MD
Northport

The author has written this column after noting, "One thing that has distressed me in reading medical association publications recently is the scarcely-concealed anger in much of what I see. Now there's nothing wrong with righteous indignation, and I've felt plenty of it in my "downstate" days, but I have also felt for a long time that there is a whole other side to medicine which just isn't receiving the press it deserves. 'Country Doc's Notebook' is, among other things, dedicated to that proposition."

* * *

I sing of a lost word.

Not lost, perhaps, only misplaced or forgotten; a set-aside, out-of-fashion word, a misinterpreted, undervalued word, disfigured by over-use at inappropriate times and in unseemly places. Diminished by synonyms old and new that are innocent of its true depth of meaning, it starves for lack of use.

I sing of love.

It has no equal in the English language, but many substitutes and pale, distorted and impotent successors.

We speak of caring, and develop useful, but harmless and tepid theses on that noble impulse.

We speak of ethics, and erect whole schools and word-structures of philosophy on the word, with branching and budding subdivisions that enlighten — and confuse.

We speak of manners, and of morals and character, little understanding or aware of their origins; and we divert ourselves by shallow words and stiff actions from what, in our hearts, we really intend to say and do.

Afraid to love

We are afraid of love — afraid to love and be loved — and partly because of this fear, too seldom use the strongest healing tool man can possess. Or if we use it (for I'm satisfied that a great many of us do) we use it halfheartedly, nearly ashamed, fearful we'll be misunderstood.

Genuine love absorbs anger, that most potentially destructive of emotions, and lets it play itself out.

Love surpasses understanding and interpretation; makes all things possible; creates hope where there seemed to be none; cures in ways that defy reason.

Love will not be circumscribed nor cheapened. In the end, its life-giving, life-sustaining reality cannot be denied.

But it can seem to be lost — as our times seem to have lost it — as other times have.

Consider it well, dear friends and associates. When did you last embrace a bereaved wife or husband, a frightened or overwhelmed person in the corridor of your hospital, or in your office? When did you last sit, perhaps tearfully, by a suffering or lonely patient, and share, in silence, the love that needs no words, no explanation nor excuse?

Consider it. Seek it out in unexpected places, and most especially in apparently unlovable people. Exercise your birthright of privileged humanity.

Love's time now

As physicians, much has been given us, and much is expected. Our potential reservoir of love is inexhaustible. But we tire, too — become exasperated, harrassed, and angry — and sometimes ill ourselves. Our very human-ness wills it to be so.

But there is no secret to the capacity for and the realization of this loving; no equations by which it can be derived.

It is simply there to be experienced, practiced and shared. Love's time is — has always been — now; its place here.

A forgotten word? I know otherwise.

(A bibliography will be provided on request.) ◥

Doctor Cooksey is head (and comprises all) of the department of internal medicine at Leelanau Memorial Hospital, Northport. He formerly served on the staff of William Beaumont Hospital, Royal Oak.

News

New president of the Michigan Orthopaedic Society is **Richard H. Allen, MD**, Battle Creek.

Recipient of the Black Caucus of Health Workers Award for 1977 is Ann Arbor physician **Solomon J. Axelrod, MD**, professor of medical care organization at the University of Michigan School of Public Health. Doctor Axelrod was honored at an awards dinner of the BCHW, American Public Health Association.

The American Society of Clinical Pathology and the College of American Pathologists presented the "ASCP-CAP Distinguished Service Award" to **A. James French, MD**, Ann Arbor, in recognition of his outstanding contribution to the profession and to the ASCP and CAP.

John A. Gronvall, MD, Dean, University of Michigan Medical School, is the new chairman-elect of the Association of American Medical Colleges (AAMA).

H. Sidney Heersma, MD, Kalamazoo, was honored by 32 local pediatricians and their wives at a special dinner in recognition of Doctor Heersma's 40 years of practicing pediatrics.

The Iron Mountain board of education presented a plaque to **Donald J. Jacobs, MD**, in appreciation of his service to the school district's athletic programs. Doctor Jacobs was recognized for giving physical exams to Iron Mountain athletes and administering medical care to injured players.

Alex P. Kelly, MD, is new president of the Detroit Surgical Society. President-elect is Donald C. Austin, MD.

Rosser L. Mainwaring, MD, Dearborn, is recipient of two awards from the recent joint meeting of the American Society of Clinical Pathologists and College of American Pathology: the ASCP Ward Burdick Award and ASCP Commission on Medical Personnel Recognition Award.

MSMS President Vernon V. Bass, MD, Saginaw, center, presented special awards this year to five medical reporters for Michigan daily newspapers. Among them were Millicent Lane, left, *State Journal*, Lansing, and William Cote, Booth Newspapers, Lansing. Other recipients of the MSMS Presidential Citations for outstanding continuing journalistic efforts to explain health care and medically-related issues to the public are Larry Bush, *Ann Arbor News;* Jane Haradine, *Grand Rapids Press;* and Nancy Konesko, *Saginaw News*.

Joseph R. Montante, MD, Pontiac, is serving his third term on the Oakland County Board of Commissioners. In addition to chairing the Sanitary Code Board of Appeals, and Zoning and Coordinating Committee, Doctor Montante serves on several other county committees, commissions, and boards.

Flint physician **Alfred E. Neuffer, MD**, is a new appointee of the national advisory board of Mended Hearts, Inc., an organization dedicated to helping heart attack victims before and after surgery.

The new medical director of the Midland County Health Department is **Winifred L. A. Oyen, MD**, Freeland.

Marquette obstetrician/gynecologist **Wallace G. Pearson, MD**, is recipient of the Alan D. Guttmacher medallion by the Marquette-Alger chapter of the Northern Michigan Planned Parenthood Association. Doctor Pearson was honored for his contribution in founding and directing the local planned parenthood birth control clinic.

Robert Pool, MD, Birmingham, is new president of the Education Foundation of the American Society of Plastic and Reconstructive Surgeons.

The Michigan Academy of Family Practice named **Francis P. Rhoades, MD, Detroit**, "Family Physician of the Year" during its 31st Annual Postgraduate Clinic at Sugar Loaf Village, Cedar. Doctor Rhoades is a past president and past secretary of the Academy.

Alfred B. Swanson, MD, Grand Rapids, is returned from lecture tour in South Africa. Doctor Swanson addressed the South African Society of Surgery of he Hand and the 23rd South African Orthopaedic Congress in Durban, spoke at the University of Cape Town, the University of Stellenbosch near Cape Town, and the University of Witwatersrand in Johannesburg.

The American College of Emergency Physicians has selected **Judith E. Tintinalli, MD, Detroit**, Emergency Case Conference editor of JACEP, to complete the final editing of its emergency medicine condition/skill worksheets to be used as the study guide for those taking the certification examination.

Michigan physicians elected to leadership posts by the American Society of Clinical Pathologists are: vice president, **Frank B. Walker, MD,** Grosse Pte. Farms; treasurer, **Herbert I. Krickstein, MD,** Detroit; medical laboratory personnel commissioner, **James J. Humes, MD,** Detroit.

Richard H. Walker, MD, Royal Oak, and **James J. Humes, MD,** Detroit, are recipients of Distinguished Service Awards from the American Society of Clinical Pathologists for their outstanding contribution to the ASCP Commission on Continuing Education.

John R. Wilson, MD, Grand Rapids, is new president of the Michigan Medical Practice Board. Elected to serve as vice president of the Board is Donald H. Kuiper, MD, of Lansing.

Michigan authors . . .

Bernhard A. Kats, MD, authored "Prison Medicine" which was published in the *Canadian Family Physician*. Doctor Kats is associate professor of medicine in the office of health services education and research at Michigan State University's College of Human Medicine. From 1974 to 1975 he developed and directed a comprehensive prison health service in a state prison in Ohio.

An article entitled, "Your Annual Physical Will Take a Year to Complete, Mrs. Jones" has been written by **Edwin H. Gullekson, Jr., MD,** of Flint, and appears in the September 19, 1977 issue of *Medical Economics*. **Louis R. Zako, MD,** Dearborn Heights family physician and vice chairman of the MSMS Council, is one of the panelists to whom the question was asked, "How Would You Cope with These Ethical Dilemmas" in an article by that title in the November 28 issue of *Medical Economics*. Dilemmas posed to the experts were the terminal patient planning suicide, a husband who comes home with VD, a consultant who wants to take over, and a patient's request for Laetrile. ◥

Republican task force studying Michigan physician distribution

By Gene Hashley
Special to Michigan Medicine

A special House Republican Task Force on Health Manpower Resources expects to issue a comprehensive report early this year on its study of physician maldistribution in Michigan.

This report will contain recommendations designed to solve the critical physician shortage that now exists in rural and inner-city areas, according to its chairman, State Representative Bela Kennedy (R-Bangor).

Dennis Paradis, staff director for the Task Force, said the group has received excellent cooperation and input from several physicians and public health support groups.

Among those assisting the Task Force were Robert E. Rice, MD, Greenville, Michigan's AMA delegation chairman and member, state and national family practice associations; H.E. "Pat" Crow, MD, director, family practice, E. W. Sparrow Hospital, Lansing; Terry Burge, MD, affiliated with the Family Practice Center in Mason; and Van Keeler, MD, Otsego; Henry Schneiter, MD, Allegan; Dale Morgan, MD, South Haven; Michael Curtin, MD, Escanaba; Joseph Cooper, MD, St. Joseph and Thomas Payne, MD, of Lansing.

Cooperating groups were the Michigan Health Council, Michigan State Medical Society, Michigan Medical Schools' Council of Deans, Michigan Nurses Association and the State House Officers Training Service.

In its early study phase, the task force concluded that Michigan has more than adequate physician resources to provide service to all residents of the state and the educational potential to maintain this physician surplus.

"The main question then," Kennedy says, "is why certain areas of the state are medically underserved?"

Kennedy and his colleagues traveled throughout Michigan's rural and inner-city areas during September to seek answers. They held public hearings to allow medical professionals and residents to contribute to the task force study.

Prior to the public hearings, the task force developed eight reasons it felt physicians were discouraged from practicing in rural and inner-city areas.

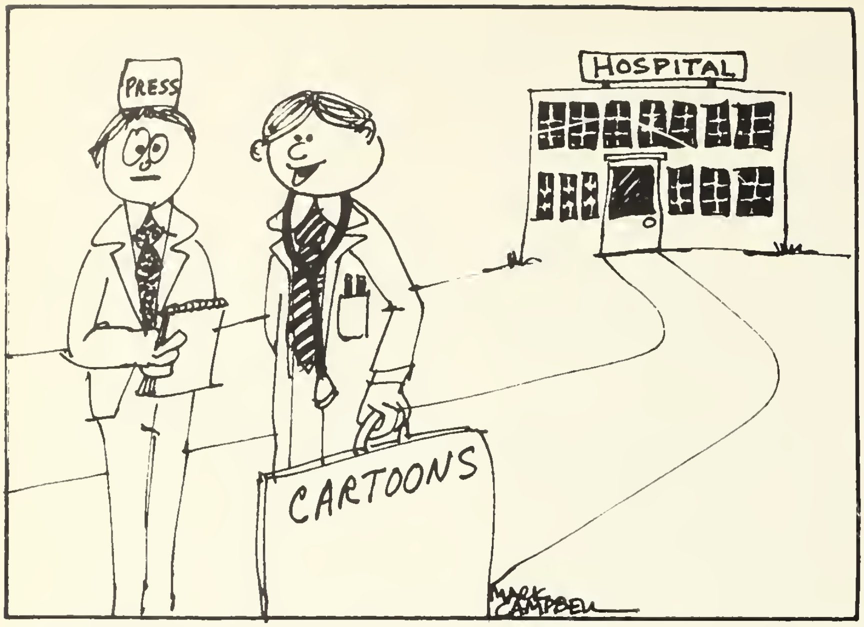
Kennedy says those eight reasons are longer hours, limited access to continuing education which is required by law, lack of professional stimulation from peers, less access to group practice, lack of sophisticated support, negative reaction by spouse, lack of managerial experience and limited social, cultural and educational opportunities.

"Additionally we have found a variety of other reasons such as high medical malpractice insurance rates, the unequal reimbursement by third party payers and lack of community support," Kennedy said.

"We also found the medical educational community is not emphasizing general practice or family practice even though the greatest need is in this area," he added.

Kennedy said he expects the task force recommendations to include both legislative and non-legislative solutions to this problem.

Other members of the task force are State Representatives W. V. "Sandy" Brotherton (R-Farmington), Ernest W. Nash (R-Dimondale), Donald VanSingel (R-Grant) and E. Dan Stevens (R-Atlanta).



Now, Butterworth Hospital has every subspecialty represented, including a Cartoon consultant.

Mark Campbell cartoons, too

By Jane Haradine
Grand Rapids

Doctor Mark Campbell sees the funny side of life.

With deft strokes of his pen, he captures the ridiculous, the comical and the satirical.

Most of his ideas come, naturally, from the field of medicine, for Doctor Campbell is in his final year of an internal medicine residency at Butterworth Hospital in Grand Rapids. Next year, he starts a two-year fellowship in cancer at Ford Hospital in Detroit.

But after a hard day at the hospital, Doctor Campbell enjoys cartooning. "It's very relaxing," he says. He usually has jotted down an idea or two for a gag line.

But his fleeting memory has prompted him to add paper and pencil to his bedside stand to record those gems that come to him at the end of the day.

"My most productive time is just before I go to bed," he says. "But if I didn't write the idea down, I'd have forgotten it by morning, and it might take me a week to remember it."

Two hundred cartoons

Doctor Campbell has produced about 200 cartoons. *Michigan Medicine* has published quite a few to illustrate articles or simply to provide a chuckle.

On the long hours of medicine, he drew a doctor as a trucker. The line read: "That's the doctor. He joined the Teamsters in order to get weekends and holidays off."

Doctor Campbell says the drawing is the easy part. "The biggest limiting agent is ideas." He tried working with a writer to get gag lines, but had little success. Sometimes other doctors give him usuable material.

Some cartoons, he says, are funny because of the saying. Others, he says, "are so cute, they hardly need words. The classy guys are the ones who can do both."

At each drawing session, Doctor Campbell tries to complete three or four cartoons. Except for a few pencil marks to position the characters, he does each drawing in ink. "You must draw it in quickly; it looks more natural."

Doctor Campbell's drawing talent was discovered in high school. When it came to the production of posters, design of backdrops for plays and illustrations for programs, he was the "volunteer."

While still a student at North Farmington High School, Farmington, Doctor Campbell competed in a national art show, exhibiting his work in 12 different media. Although he won a scholarship in art to Miami University, he turned it down.

Medicine first choice

"I've always had it in the back of my mind that I wanted to be a doctor," he says.

He also recognizes his style has certain limits. "Very early I could see I couldn't get into serious portrait work," he said. "Whenever I tried to do a realistic portrait of someone it always came out funny," he says.

The Christmas cards he did were in the same class — comical.

Doctor Campbell received his MD degree from Wayne State University, taking an extra year for his undergraduate work because he combined science with art. "They were so busy with art classes that you couldn't take any art unless you were enrolled in the Art Department."

But his art classes aren't wasted. In fact, Doctor Campbell is critical of the educational process generally because it emphasizes football and cheerleading instead of more usuable leisure-time activities.

"I learned football, but now I'm too busy to get 22 guys together," he says. "I never learned tennis. I never learned downhill skiing or cross-country skiing. I never learned jogging."

High schools, he said, "should encourage people to learn things that will be useful to them as adults."

For Doctor Campbell that something is art.

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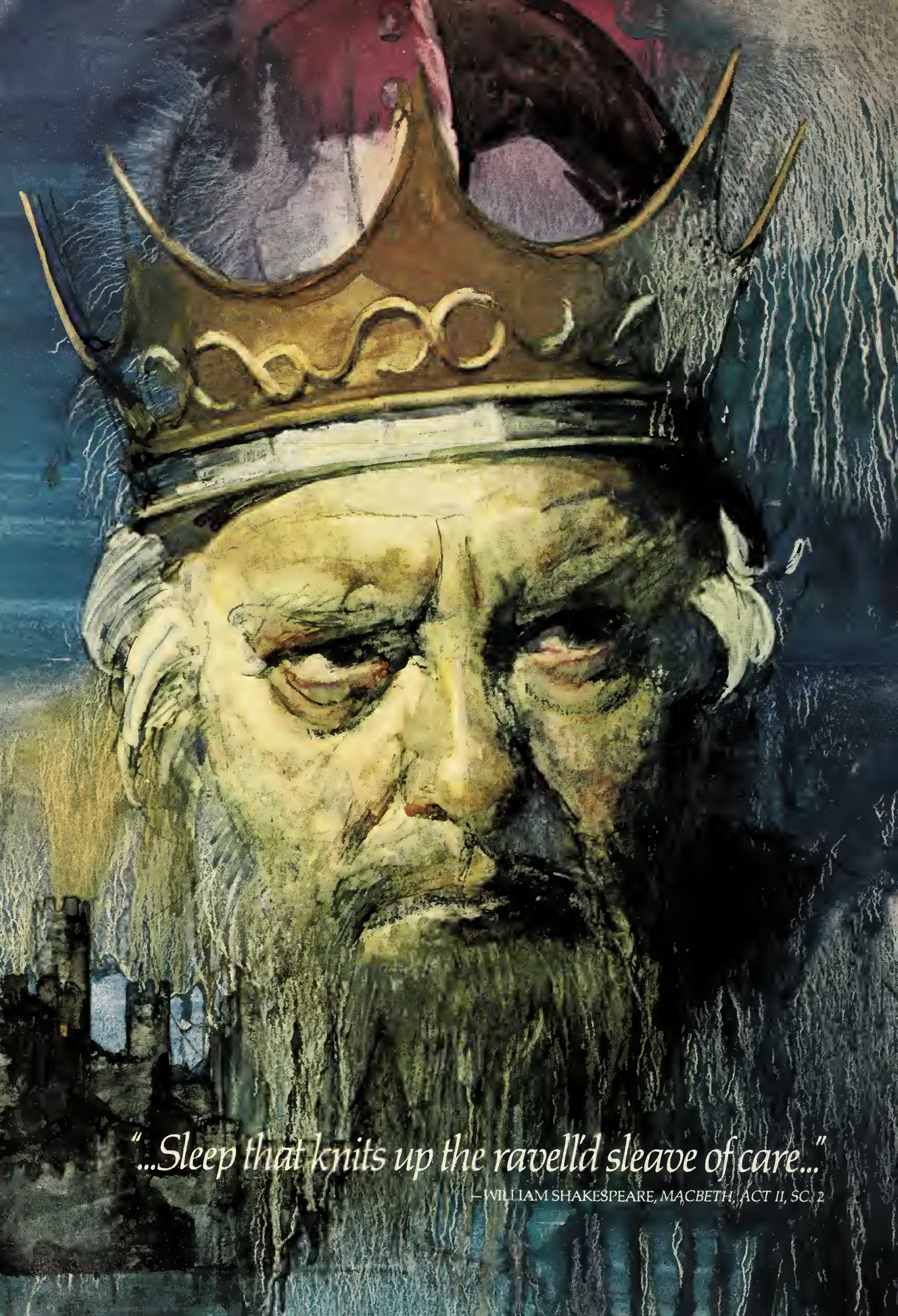

"...Sleep that knits up the ravell'd sleave of care..."

—WILLIAM SHAKESPEARE, *MACBETH*, ACT II, SC. 2

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a shade of blue that often accompanies depression

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.

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Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

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Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat No. 3,056,836

VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

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and glyceryl guaiacolate (guaifenesin)
90 mg. Elixir: alcohol 15%

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- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

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Courses

***Michigan Medicine** each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Because of space limitations, it is not possible to list the many continuing courses and series sponsored by many hospitals and organizations in Michigan. Information about those possible programs may be obtained from the accredited sponsors.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Bay County Medical Education
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
Universityof Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo State Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V.A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: Jan. 4, 11, 18, 25; Feb. 1 & 8, 1978, Forensic Psychiatry for the Non-Forensic Psychiatrist. Location: Fisher Auditorium, Providence Hospital, Southfield. **Sponsor:** Providence Hospital. **Co-Sponsor:** The Michigan Psychiatric Society Rotating Lecture Series. **For:** Psychiatrists. **Cost:** $25. **Contact:** 313/493-6212. **Approved for:** 9 hours of Category I Credit.

Date: Jan. 18, Meadow Brook Lecture Series in Medicine and Surgery, "Disordered Lipid Metabolism — The Mechanics and Treatment." Location: Meadow Brook Hall, Rochester. **Sponsor:** Oakland Health Education Program. **For:** All specialties. **Cost:** $75 for whole series (four lectures), $20 each individual lecture. **Contact:** Gail Anne Rassier, Administrative Secretary, Oakland Health Education Program, 268 South Foundation Hall, P.O. Box 84, Rochester 48063, 313/377-4360. **Approved for:** 2 hours of Category I Credit.

Date: Jan. 20, "Aerobics and Preventive Medicine." Location: Long's Convention Center, Lansing. **Sponsor:** Central District Dental Society. **Co-Sponsor:** Ingham Medical Center. **For:** All specialties. **Contact:** M. H. DeLuca, DDS, M. S. Nasif, DDS, Program Chairman, 3320 W. Saginaw, Lansing 48917, (517) 321-4254. **Approved for:** 6 hours of Category I Credit.

Date: Feb. 5-10, Michigan-Indiana Family Practice Update. Location: Boyne Highlands. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians-Indiana Academy of Family Physicians. **Cost:** $175 for physicians, $90 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21½ hours of Category I Credit.

Date: Feb. 5-10, Michigan-Indiana Midwinter Family Practice Update. Location: Boyne Highlands. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-sponsor:** Michigan Academy of Family Physicians, Indiana Academy of Family Physicians. **For:** Family physicians. **Cost:** $175 for practicing physicians; $90 course fee for physicians-in-training. **Contact:** Jan Johnson, Program Director, Towsley Center, University of Michigan, Ann Arbor, MI 48109, 313/764-2287. **Approved for:** 20½ hours of Category I Credit.

Date: Feb. 10-11, Topics in Adult Psychiatry. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 11¼ hours of Category I Credit.

Date: Feb. 14, Sexually Transmitted Diseases. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 7 hours of Category I Credit.

Date: Feb. 16, Lansing OB/GYN Symposium 1978. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** Sparrow Hospital, Michigan Society of Obstetrics and Gynecology, Lansing Obstetrical and Gynecological Society, Michigan State University College of Human Medicine. **For:** Obstetricians/Gynecologists. **Contact:** Richard Pomeroy, MD, Lansing*** **Approved for:** 4 hours of Category I Credit.

Date: Feb. 20-24, Emergency Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** American College of Emergency Physicians. **Cost:** $225 for physicians, $125 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 36¼ hours of Category I Credit.

Date: Feb. 28, Continuing Pathology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 6½ hours of Category I Credit.

Date: March 1, Cooperative Chemotherapy Review. Location: School of Medicine. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Contact:** Wayne State University, Division of CME, WSU School of Medicine, 1206 Scott Hall, 540 E. Canfield, Detroit 48201, 313/577-1180. **Approved for:** 3 hours of Category I Credit.

Date: March 8-10, Hemotology Review. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21 hours of Category I Credit.

Date: March 8-9, Conference on Maternal and Perinatal Health. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **Co-sponsor:** Michigan Section, Nurses Association, ACOG. **For:** Ob/Gyn, pediatricians, family physicians, nurses. **Contact:** Herb Auer, MSMS headquarters, 517/337-1351. **Approved for:** 14 hours of Category I Credit.

Date: March 15, Meadow Brook Lecture Series in Medicine and Surgery, "Anaerobic Infections." Location: Meadow Brook Hall, Rochester. **Sponsor:** Oakland Health Education Program. **For:** All specialties. **Cost:** $75 for series, $20 each lecture. **Contact:** Gail Anne Rassier, Administrative Secretary, Oakland Health Education Program, 268 South Foundation Hall, P.O. Box 84, Rochester 48063. **Approved for:** 2 hours of Category I Credit.

Date: March 16-17, Newer Concepts in Gastrointestinal Surgery. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $130. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 22-23, Advances in Pediatrics. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $120. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 30-31, The Spine and Spinal Cord. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 31-April 1, Advanced Cardiac Life Support Certification Course. Location: The Kellogg Center for Continuing Education, Michigan State University, East Lansing. **Sponsor:** Michigan Heart Association. **Co-sponsor:** Michigan State University College of Osteopathic Medicine and Ingham Medical Center. **For:** All specialties. **Cost:** $160 physicians; $100 EMTs. **Contact:** Ann Tsiminakis, Conference Coordinator, Continuing Education MSU, Kellogg Center, 517/353-7822. **Approved for:** 16 hours of Category I Credit.

Date: April 3-7, Occupational Skin Diseases. Location: Detroit. **Sponsor:** Wayne State University School of Medicine Div. of Continuing Medical Education. **For:** All specialties. **Cost:** $250. **Contact:** Wayne State University Division of CME*** **Approved for:** 22½ hours of Category I Credit.

Date: April 6-7, Ophthalmology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education.* **Cost:** $140. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: April 12-13, Symposium on Child Development. Location: Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association. **Co-Sponsor:** SMAHEC. **For:** Pediatricians, family practitioners, obstetricians. **Contact:** Valerie Lincoln, RN, Perinatal Coordinator, Bronson Hospital, 252 E. Lovell, Kalamazoo, 49007.

Date: April 13, Medical Aspects of Organized Athletics. Location: Longs Convention Center, Lansing. **Sponsor:** Michigan State Medical Society. **For:** Team doctors, coaches, athletic trainers. **Contact:** Herb Auer, MSMS headquarters, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 14-15, The Wayne State University School of Medicine 11th Annual Cancer Symposium, "Cancer of the Colon and Rectum." Location: Gordon H. Scott Hall, 540 E. Canfield, Wayne State University, School of Medicine, Detroit 48201. **Sponsor:** Wayne State University. **Co-Sponsor:** American Cancer Society, Michigan Division. **For:** Primary care physicians. **Cost:** $50. **Contact:** Melvin L. Reed, MD, FACP, Associate Professor, Department of Oncology, 4160 John R., Detroit 48201. **Approved for:** 12 hours of Category I Credit.

Date: April 17-21, Family Practice Review II. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 37 hours of Category I Credit.

Date: April 25, Continuing Pathology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 6½ hours of Category I Credit.

Date: April 27-29, Critical Care Symposium. Location: Wayne County Medical Society Headquarters. **Sponsor:** Wayne State University School of Medicine Div. of Continuing Medical Education. **For:** All specialties. **Contact:** Wayne State University Division of Continuing Medical Education,** **Approved for:** Undetermined hours of Category I credit.

Date: May 4-5, The High-Risk Infant. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $75. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 12 hours of Category I Credit.

Date: May 10-12, Pediatric Clinic Days. Location: Children's Hospital, Detroit. **Sponsor:** Wayne State University School of Medicine Div. of Continuing Medical Education. **For:** Pediatricians. **Contact:** Wayne State University Division of CME** **Approved for:** Undetermined hours of Category I Credit.

Date: May 22-26, Internal Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 33½ hours of Category I Credit.

Date: May 24, Meadow Brook Lecture Series in Medicine and Surgery, "The Current Status of the Coronary Bypass Operation." Location: Meadow Brook Hall, Rochester. **Sponsor:** Oakland Health Education Program. **For:** All specialties. **Cost:** $75 for series, $20 each lecture. **Contact:** Gail Anne Rassier, Administrative Secretary, Oakland Health Education Program, 268 South Foundation Hall, P.O. Box 84, Rochester 48063. **Approved for:** 2 hours of Category I Credit.

June 8-10, Keyport-Gaylord Trauma Symposium. Location: Gaylord. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $25. **Contact:** Wayne State University, Division of CME.** **Approved for:** 12 hours of Category I Credit.

Date: June 25-30, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $200. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21½ hours of Category I Credit.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't of PBM/HPE, Ann Arbor, 48109.

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453.

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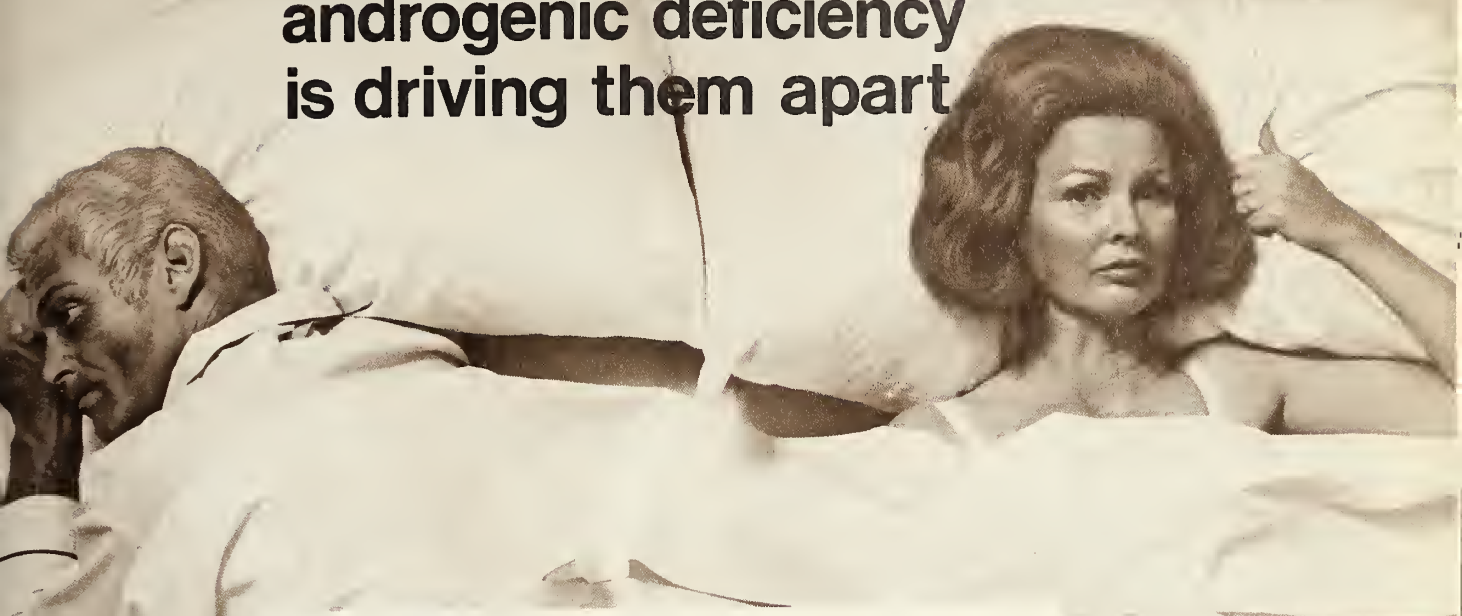

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*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Placental registry review shows research needed

Analysis of the Michigan Placental Tissue Registry's first 500 cases points to a continuing need for research on the immunological role of the placenta in protecting the unborn infant.

This is the view of Charles H. Sander, MD, professor and assoicate chairman, MSU Department of Pathology, who reported recently on placental tissue research.

"If there is exposure to viral infection during the first few months of pregnancy, the placenta may not be immunologically competent enough to react to the virus," Doctor Sander said. "The virus may pass unhindered from the mother through the placenta into the fetus, causing congenital anomalies or defects."

If viral exposure occurs later in pregnancy, the placenta may be more fully immunologically competent — and there is a battle fought within the placenta which prevents the virus from getting to the child, Doctor Sander suggested.

"Although this is conjecture and theory," he said, "the complexities of the placenta's protective role pose an important area for additional study."

Results from viral infection in the mother and infant during pregnancy or even before pregnancy, are linked to a condition called chronic fibrosing villitis, a form of chronic placentitis which may be associated with infant malformations and even death.

Some viruses under suspicion as causes, according to Doctor Sander, are rubella (measles), vaccinia, and cytomegalic inclusion disease. Another suspect is a protozoan parasite called toxoplasma (toxoplasmosis), which also may cause fibrosing villitis and infant abnormalities. Selected cases from the registry are being studied using special techniques to localize antibodies in the placenta and more fully delineate this lesion.

Another placental condition sometimes but not always associated with infant abnormalities and infant death is aging of the maternal blood vessels. Other information arising from the placental research supports earlier findings calling for "examination at birth of the blood vessels of the umbilical cord to detect evidence of possible birth defects."

Ten of 45 infants with birth defects in the placental tissue research were missing one of the usual two arteries in the umbilical cord.

"It behooves the obstetrician to examine the cord closely at childbirth," Doctor Sander affirms, "and to suspect a birth defect or anomaly in the newborn if an umbilical artery is missing."

Placental Tissue Registry activities and research now are directed by Doctor Sander and Henry A. Kallet, MD, associate professor of pathology. Interim director Larry Nathan, DO, now at Detroit's Sinai Hospital, also is associated with the project.

Sponsors of the registry include the Michigan Department of Public Health and MSMS.

LCC offers credit hours for taking good care of your heart

Lansing Community College is offering three unique for-credit courses related to cardiac health. They range from maintenance and physical fitness to cardiac rehabilitation following hospitalization.

Health Maintenance and Physical Fitness, an introductory course, is designed for those who want to improve their physical condition. Participants receive guidance in developing the skills needed to establish, monitor, and evaluate aerobic exercise activities. Subject matter includes an introduction to risk factors identified in cardiovascular-pulmonary disease, with special consideration given to stress in individual life styles.

The second course, Adaptive Cardiac Rehabilitation and Exercise, is for persons with cardiovascular problems or those who run a high risk of such problems. It introduces prescribed aerobic exercises and shows their effect on the cardiovascular physiology. The pace and type of exercise are determined by the individual's personal physician, or by the program's cardiologist, Walter Baird, MD, Lansing, a medical director who is on hand to monitor and assess heart rates. The course emphasizes early detection of clinical symptoms or complications.

The third course, Adaptive Cardiac Rehabilitation, is designed for the recent heart patient. The major focus is on the psychosocial and physiological aspects of adjustment to heart disease, and includes specialty areas such as nutrition and diet, available social services, vocational rehabilitation, the benefits and myths of exercise, activity and recreation, and counseling. A close family member is encouraged to attend the sessions as a student, in order to understand and facilitate rehabilitation.

Members of Lansing Community College's unique for-credit cardiac care classes as they improve their health.

The program was begun by its medical director, Walter Baird, MD, Lansing, and Carol Thelan, program director, continuing education, Health Careers Department, at Lansing Community College.

"We had patients who wanted to continue on a rehabilitation program and others who wanted a good physical fitness program. The courses seemed well-suited to LCC with its philosophy as a community resource."

The LCC program is the only one in the country of its scope based in a community college, as far as Doctor Baird knows. He encourages physicians in other parts of the state to look into their community colleges as a good site for such cardiac care and physical conditioning programs.

"You already have peoples' interest in the college as a location and the facilities are there to allow for a place to carry on year-long," he says.

The cardiac disease prevention program of the LCC program also is unique, according to Doctor Baird.

Primarily, patients come to the cardiac disease prevention and rehabilitation courses by physician referral. The physical fitness course is open to anyone interested. Physicians who would like to learn more about the LCC program may contact Doctor Baird at Ingham Medical Hospital, Lansing, or Carol Thelen at Lansing Community College.

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New HEW report reveals status of nation's health

The U.S. Department of Health, Education, and Welfare has sent to Congress a new report on the nation's health.

A 26-chart synopsis of the report reveals some dramatic comparisons on improvements and problems in American health and the cost of the health system. Among the comparisons:

— The national health bill increased from $12 billion in 1950 to more than $139 billion in 1976, rising from 4.5 percent of the Gross National Product to 8.6 percent last year.

— Hospital care accounted for 31 percent of health costs in 1950, 40 percent in 1976, while drugs and drug sundries dropped from 22 percent to 19 percent during the same period.

— Government is now the biggest bill-payer for health, footing 40 percent of the nation's health care costs, followed by direct payment by the patient (33 percent) and private health insurance (26 percent).

— In 1976 the government paid 55 percent of the cost of all hospital care and 55 percent of all nursing home care.

Several indicators of individual health are included among the charts.

Infant mortality rates are shown as declining steadily for the past 10 years for both black and white infants. The rate of decline during the past decade is somewhat more rapid for black than for white infants but not enough to achieve equal rates in the near future.

Death rates for young people aged one to 24 years declined slightly in the past two years, the charts show, but the rate for males aged 15 to 24 was as high in 1975 as it was 25 years earlier, reflecting a rise in violent deaths, primarily accidents.

Hypertension is substantially more prevalent among black adults than among white adults in the U.S., afflicting 50 percent of black men, but only 31 percent of white men aged 55 to 64. In the same age group hypertension afflicts 55 percent of black women and 32 percent of white.

More than a quarter of 12-to-13 year-old male students and two-thirds of all 18-to-20-year-old male high school students were classified as moderate or heavy drinkers in 1974. That is, they had at least one drink once a week, two drinks three times a month, or five drinks once a month. The proportion of female students who were moderate or heavy drinkers is lower than for the males in the teenage years, ranging from 34 percent at 12-to-13, to 63 percent at 18 and over.

The percentage of girls who smoke regularly has increased from 1968 to 1974, from 19 percent to 26 percent of girls 17-to-18 years old. Smoking among boys in the same age group increased slightly, from 30 to 31 percent.

Among adults, the biggest decline in smoking occurred among men aged 21 to 24. Some 41 percent of those were regular smokers in 1975, compared with 64 percent 10 years earlier. A slight increase, from eight percent to 10 percent, was noted among women aged 65 and older, and the proportion of smoking women increased from 21 percent to 26 percent in the 55 to 64 year age group.

Obesity, another precursor to health problems, was found to be more prevalent among women than men during 1971-1974. Among women in their middle years (45 to 64), 35 percent of those living below the poverty level and 29 percent of those above, were rated obese. In the same age group, five percent of the men below the poverty level, and 13 percent of those above, were rated obese.

The chart summary was prepared by the National Center for Health Statistics, a component of HEW's Public Health Service.

The full report, "Health, United States, 1976-1977," in addition to carrying detailed tables on which the charts were based, includes additional data on health status, utilization of health resources, the availability of health care resources, and health care expenditures, as well as special interpretive sections on health and the elderly, hypertension, geographic variations, and national health insurance.

The chartbook, DHEW Publication No. (HRA) 77-1233 is available from the Scientific and Technical Information Branch, National Center for Health Statistics, Room T-57, Center Building, 3700 East-West Highway, Hyattsville, MD 20782.

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KAON® (potassium gluconate) TABLETS

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Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is the test of all things

tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

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By David Buegeleisen
Southfield

Help with the burden of managing retirement trusts

(This article is presented as a companion piece to the earlier article, "A simple investment program for your retirement trust," which appeared in the September issue of Michigan Medicine. This article is designed to aid physicians and professional corporations with large trust funds to manage. The earlier article dealt with small trusts.)

As the practice of medicine has become more complex and demanding, many physicians in solo practice have found themselves with large office staffs. In these cases, pension and profit sharing trusts rapidly grow to a size that places large demands on the trustess.

In addition to the demands upon your time in managing the large trust program, there are the requirements set down in the Employees Retirement Income Security Act of 1974, known as ERISA, which must be met. If these requirements are not met, the trustees are personally liable for their actions as the law gives employees the right to sue for mismanagement of the trust.

Relief from the burdens of managing the larger pension and profit-sharing trust is readily available. Realizing trustees will require this help, the ERISA encourages but does not demand the hiring of outside investment counsel. However, the law does specifically state that only bank trust departments, registered investment counselors, and insurance companies may be hired as advisers to the trusts.

Most banks have trust departments which will invest trust assets and do all of the accounting up to and including the preparation of tax forms. Bank trust departments are generally cautious and conservative. They are particularly well suited to invest trust assets in fixed income securities (bonds). Several Michigan banks have shown excellent performance in this area and their charge for administration of a bond program is usually low. Bank trust departments also are useful in acting as custodians for the assets of the trust where investment management comes from another source such as an investment counselor or one of the trustees.

Investment counselors will design and execute a program to meet the goals set by the trustees. There is considerable difference in investment counselors. Very large investment counseling firms will, in general, perform similar to a bank trust department. A smaller investment counseling firm will have more flexibility and give more individual attention. The problem with smaller firms is that there is less guarantee of continuity. Investment counselors are registered with, regulated by, and subject to audit by the Securities & Exchange Commission.

Insurance companies' programs generally are used by very large pension and profit-sharing trusts. Insurance companies offer investments which guarantee rates of return for periods of five to 10 years. These programs generally are used in place of a fixed income fund managed by either a bank trust department or investment counselor. These guaranteed income investments are most often used in a defined benefit program — not in a money purchase plan.

It is extremely important to choose advisers carefully, as the law holds trustees personally liable even if they have hired a bank trust department, investment counselor, or insurance company. In selecting an adviser for a trust, it is important not only to have someone who meets the qualifications of the law but someone who has a record of performance that justifies selection.

Therefore, physicians should ask any investment counselor or bank trust department for records of past performance. All bank trust departments have co-mingled funds whose past performance will be provided upon request. Any investment counselor should be happy to provide you with past performance records. It is important to look at performance in good markets and bad — especially bad markets. The major question to be asked is "Has this performance record increased the funds under management and at what rate?" Good performance is the best defense against lawsuits.

In these trusts most investments will be in some combination of life insurance, stocks, and bonds. The proportion of each will determine the rate of return and risk. If a higher fixed rate of return with low dollar risk is decided on, then a largely bond portfolio is indicated. If a higher rate of return is desired, then a larger percentage of the assets will be invested in stocks, which provide a much better opportunity for capital appreciation than bonds do.

In addition to asking for performance records, physicians will want to

Mr. Buegeleisen is an investment counselor and fellow of the Financial Analysts Federation.

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Feb. 14-15, Hyatt Regency Dearborn
Feb. 16-17, Long's Convention Center, Lansing

The Workshop Program

First Day

8:00- 8:30 Registration

8:30- 9:30 Introduction

9:30- 12:30 Personnel Problems
Recruiting & Interviewing
Training & Evaluation
Job Descriptions
Setting Policies & Procedures
Task Analysis & Delegation

12:30- 1:30 Lunch

1:30- 4:00 Patient Flow Techniques
Systematizing the Telephone
Appointment Scheduling

4:00- 5:00 Physical Aspects of the Medical Office
Internal Set-up and Equipment
Financing Your Practice

Second Day

8:30- 10:30 Paperwork-Clinical
Medical Records & History Taking
Clinical Filing Techniques

10:30- 12:30 Paperwork-Financial
Financial Billing System
Financial Controls
Collection Techniques
Insurance Processing

12:30- 1:30 Lunch & Luncheon Topic
Socioeconomic Aspects of Medical Practice

1:30- 3:00 Practice Setting
Choosing Type of Practice
Location
Relationship with Hospitals, Colleagues, Professional Societies and Community

3:00- 4:45 Legal Problems
Economic Controls/Pensions/Keogh/Tax Problems
Informed Consent
Reciprocity
Professional Corporations

For reservations, please contact John Richards at MSMS headquarters.

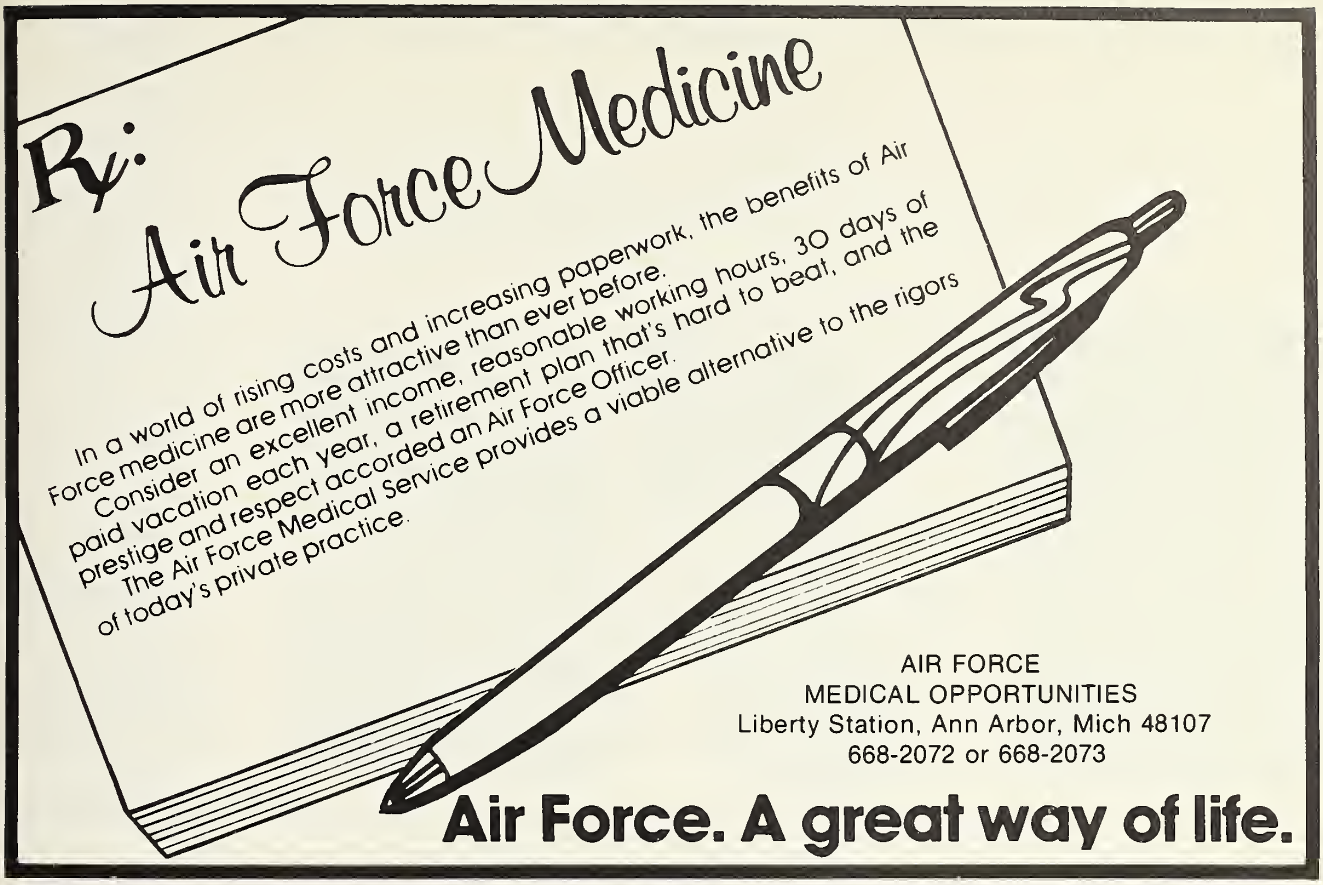
BUSINESS*/Continued*

discuss investment philosophy with a money manager. Physicians must decide whether to subscribe to the "buy and hold" theory or to the "actively-managed portfolio" theory. The "buy and hold" school says you buy good stocks and hold them — selling only when there is a negative fundamental change in the company. This is the way many bank trust departments and large investment counselling firms operate. This method was very successful during the 1950's and 60's but has not worked very well lately.

Some bank trust departments and many smaller investment counselling firms adhere to the "actively-managed portfolio" theory. They attempt to avoid market risk by the timely selling of stocks and bonds to avoid precipitous market declines and they profit by purchasing stocks and bonds to participate in market upswings.

Goals should be selected. An expected rate of return should be set. If these goals are mutually agreed upon, then there is some way of judging the performance of any adviser. If these goals are not reasonable, you cannot hope to attain them. It is vital to understand that high rates of return generally entail high risk and high risk can backfire.

No matter who is selected as adviser to a trust, the trustee's responsibilities go on. Trustees must monitor the results. If they do not meet whatever goals have been established, the trustee must consider whether to change advisers. This is a legal responsibility.



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Physicians' incomes increasing slower than most

The statistics below represent the average percentage increase in salaries or hourly wages for occupations reported to the U.S. Department of Labor, Bureau of Labor Statistics during the period 1967-75.

It is evident physicians have not realized the same increase in income as most other occupational groups.

To get an idea of the "real" increase in buying power, it is necessary to take into consideration the rate of inflation, which represents approximately 59% of the gross percentage increase. This information was compiled by the MSMS Bureau of Socioeconomics.

Percentage Increase in Salary (Hourly Rate) of Occupations, 1967-1975

Attorneys[1]*	91.6% increase
Service workers (average hourly wage)	84.7% increase
Production workers manufacturing durable goods (average hourly wage)	80.2% increase
Fire fighters (annual salary)	80.0% increase
Police (annual salary)	79.0% increase
Truck drivers, unionized (average annual wage)	76.8% increase
Production workers manufacturing nondurable goods (average hourly wage)	74.5% increase
Building tradesmen, unionized (average hourly wage)	73.4% increase
Teachers (cities with populations over 100,000)	71.1% increase
Accountants[1]	70.0% increase
Senior accountants[1]	69.8% increase
Retail store workers (average wage)	69.0% increase
Directors of personnel[1]	65.9% increase
Printers, unionized	65.7% increase
Auditors[1]	61.6% increase
Chemists[1]	61.2% increase
Buyers[1]	60.0% increase
Physicians ($34,740 in 1967, $53,600 in 1975)**	54.3% increase
Job analysts[1]	54.2% increase
Engineers[1]	53.4% increase

[1] Highest salary classification for position

*U.S. Department of Labor, Bureau of Labor Statistics, *Handbook of Labor Statistics*, 1976, Bulletin No. 1905.

***Profile of Medical Practice, 1977*, ed. by Sharon R. Henderson, Center for Health Services Research and Development, 1977.

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Travel tours beckon MSMS members

MSMS members have two exciting vacation opportunities to choose from in coming MSMS-sponsored travel tours.

Through the International Travel Advisors (Intrav) company, MSMS has scheduled a 10-day Rhine River Adventure departing June 20 from Detroit, and a 15-day Eastern Mediterranean Air-Sea Cruise departing from Detroit Oct. 8.

MSMS members, their families and friends are eligible for the trips and are advised to plan now if they wish to be included. Prices (available from Marce Ireland at MSMS headquarters) include air and sea fares, hotel accomodations, continental breakfasts and full dinners, guide and luggage services. Much free time is planned with the vacations, and side trips can be arranged.

Rhine River Trip

The Rhine River Adventure begins in Brussels, where three days are allowed for visiting NATO headquarters; the headquarters of the World Market, the "jewel of medieval architecture"— the Grand Place; and a wealth of beautiful churches and museums.

The next three days will be spent drifting down the Rhine River aboard the M/S BRITANNIA. Rhine cities to be explored are Cologne, Konegswinter, Koblenz, Brauback, Rudisheim, Gernsheimn, Heidelberg, Mannheim, Karlsruhe . . . each with its unique history, legacy and legends.

Three days in Munich will give the traveler the opportunity to enjoy the Bavarian Alps from a balcony, elegant palaces and fairy tale castles.

From there, side visits can be arranged to Salzburg or West Berlin.

Mediterranean Cruise

Plans for the Eastern Mediterranean Air/Sea Cruise call for accommodations aboard the Stella Solaris, with her Greek staff pampering the traveler.

Visits are planned to:

Pireas/Athens, where a modern cosmopolitan city contrasts with the ruins of the Acropolis and Parthenon;

Kusadasi, the gateway to Ephesus, one of the wonders of the ancient world;

Istanbul, where the belly dancers in the Sirkeci Quarters or the Blue Mosque are only two of the exotic places to visit;

Mykonos, where white houses, picturesque windmills, blue-green waters and powder soft beaches create a jewel of an island;

Heraklion, where fabulous treasures from partially restored Knossos Palace and the warmth of the tavernas reveal two of Crete's many facets.

Alexandra/Cairo, where lush Nile delta is waiting to be explored. Modern Cairo also waits with fabulous museums, or the Pyramids or Fiza, or perhaps the Sphinx.

Haifa/Jerusalem, where you'll have time to explore the many holy sanctuaries of Christianity and Judaism. Wander the ancient streets of Bethlehem and Jerusalem and let your imagination take you back in Biblical history.

The Island of Rhodes, where a donkey-back ride is only one of the ways to explore the most charming of the Greek Islands.

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New chairman of the MSMS Committee on State Legislation and Regulations is Wil E. Maldonado, MD, Lansing, left. With planning of health care delivery of key importance today, committee member Daniel S. Mazzuchi, MD, Marquette, right, is in charge of the committee's studies on that subject.

MSMS seeks better communication with MDPH

In an effort to streamline and improve communication with the Michigan Department of Public Health, MSMS created a Task Force on the Future Role of MSMS in Public and Environmental Health and Relationship to Michigan Department of Public Health.

The Task Force, consisting of representatives from MSMS and MDPH, met and agreed it was essential a structure be established that will ensure ongoing liaison between these two arms of medicine so that crucial issues and medical/health emergency situations can be studied and solutions sought promptly.

Chairman Louis R. Zako, MD, asked each member of the Task Force to submit a list of issues appropriate for discussion and study between the two groups. The Task Force expects to present specific recommendations to The Council in January regarding the composition, structure, and purposes of the proposed liaison committee.

Interest in the work of the Committee to Assist Impaired Physicians has increased, with several physicians across the state volunteering to serve as committee members. In addition, it was agreed at a recent meeting that the committee should include consultants from various organizations with similar interests, such as the Michigan Branch of the American Medical Society of Alcoholism, Michigan Psychiatric Society, Geriatrics Society, Michigan Association of Osteopathic Physicians and Surgeons, Michigan Office of Substance Abuse Services, and the Governor's Advisory Commission on Substance Abuse. Also under discussion by the Committee is a proposal to establish regional conferences to aid in training MSMS members and interviewing teams regarding the operation of the Impaired Physicians Program.

CME Programming Committee Activities Continue

By Katie Brewbaker
MSMS committee coordinator

Chairman Carl F. Hammerstrom, MD, of Marquette, has announced that the MSMS Committee on Continuing Medical Education Programming will continue to hold monthly meetings to deal with the many matters coming before the Committee. In addition to spearheading the recent 1977 Annual Scientific Meeting at the Hyatt Regency Dearborn and its present efforts to develop plans for the 1978 ASM, some of its other projects have been sponsorship of the Seminar to Improve CME Instruction on October 27-28, (which proved so successful that plans are underway for repeating the course in February or March of 1978) and launching two special sessions on Physician-Patient Communications at the Annual Scientific Meeting. Similar P-P Communication courses will be held throughout the state during the coming year. The co-sponsorship activities of the Committee on CME Programming continue, also. Meetings co-sponsored thus far have been the Michigan Joint Practice Commission regional conference, October 7-8; the Wayne County Medical Society/March of Dimes program, October 26; Perinatal Association of Michigan's "PAM Update Conference," September 8; Michigan Hospital Association's "Institute on Medical Staff Bylaws," October 18-19; and Michigan Allergy Society "Midwest Allergy Forum," October 14-16. Future co-sponsored programs include the next PAM event being held in conjunction with the 1978 Maternal and Perinatal Health Conference, March 8-9, and the Michigan Allergy Society's program March 15 on "Pulmonary Mechanisms with Prostaglandin Analogues: What is Their Clinical Future" at Long's Convention Center, Lansing and its May 17 program at Henry Ford Hospital, Detroit, on "Allergy-Immunology Research Papers."

Liability

Your good records may win a lawsuit

(The following is the second in a series of articles on risk management to appear in Michigan Medicine in coming months. It is sponsored by the MSMS Committee on Professional Liability, chaired by Robert M. Leitch, MD, Battle Creek, MSMS immediate past president. The material was originated with the Illinois State Medical Society, which has prepared tape cassettes on the subject.)

Maintaining comprehensive medical records for every patient is time-consuming, but it could mean the difference between winning or losing a malpractice suit.

In some cases, complete and accurate medical records may be all that's needed to deflate a patient's non-meritorious malpractice claim. Simply stated, if your records indicate that you exercised due care in diagnosis and treatment, it will be difficult to prove that you were negligent.

To be complete, your records should contain more than just clinical information or progress notes. Consent forms, laboratory and consultant reports, copies of correspondence and notations of conversations or other contact with the patient also can play an important role in your defense.

Your medical records should be objective and based solely on facts or considered clinical judgment. Guard against subjective statements, particularly personal opinions regarding a patient's idiosyncracies. They could prove embarrassing and may damage your defense. More importantly, do not include statements acknowledging liability in cases with adverse results.

It is advisable to keep legible records and to sign them. This includes histories, progress notes, and nurses orders and notes. If records are maintained in the hospital, you should review and sign all items daily and incorporate them into your office records. Be sure to include a signed copy of your agreement or objection to nurses notes or housestaff orders.

Remember, while actual records are the property of the physician, the patient can authorize his attorney or another physician to examine these records and obtain copies. It is advisable to require explicit, written authorization from the patient before releasing any information. *Demands to examine or copy records must be in writing. Never release the original records.*

If a patient demands a copy of his medical record, it may be an indication that he is planning to sue. *Notify your insurance company immediately.* If a complaint has already been filed, the patient's attorney may be authorized to demand a copy of your records. *Never destroy or alter any portion of your records before releasing information to a patient or his attorney.*

X-rays can be recorded on microfilm or reduced by other processes that do not alter their quality, but they must be kept by hospitals for at least five years. This five-year legal requirement does not apply to other portions of a patient's record. However, since it is impossible to predict when records might be needed, it is advisable to keep them for at least two years after the expiration of the statute of limitations. In Illinois, the maximum limitation period is four years after treatment . . . except for minors, where it stretches to four years after the patient reaches age 18. ◥

Disciplinary actions against MDs have tripled in past five years

Statistics compiled by the American Medical Association from 47 states show that the number of disciplinary actions against physicians has tripled in the past five years.

In 15 states which have enacted legislation making the reporting of professional malpractice mandatory, the number of investigations initiated by state medical disciplinary bodies has increased six-fold.

Much of this six-fold increase can be attributed to the immunity provisions for those required to report under these laws, says James H. Sammons, MD, executive vice president of the AMA.

In a study of the actions of the nation's medical disciplinary boards, the AMA found the number of disciplinary actions initiated rose nationwide from 1,275 in 1971 to 4,236 in 1976. The number of licenses revoked rose from 45 in 1971 to 130 in 1976. The number of physicians placed on probation rose from 57 in 1971 to 185 in 1976.

The AMA program consists of a three-pronged legislative effort to strengthen medical discipline. One focuses on the physically or mentally impaired physician, often a victim of alcohol or narcotic addiction or deterioration through aging. Some 30 states have enacted legislation, most after the distribution of an AMA model bill designed to deal with impaired physicians. Another AMA legislative initiative creates a broad range of flexible disciplinary actions available to the state licensing boards.

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Meetings

(See also listing of Category I programs on page 45.)

Jan. 21-22 — Mid-Winter Seminar of American Association of Medical Assistants, Inc., Adrian College Campus, Adrian, contact: Betty Suydam, General Chairman, 1129 College Ave., Adrian, MI 49201, 517/263-3046.

Jan. 25 — MSMS/INTRAV South American Adventure, contact: Marce Ireland, MSMS headquarters.

Feb. 3-10 — Michigan Doctors Study Club, Study/Ski Seminar, Snowmass/Aspen, contact: Thomas R. Berglund, MD, c/o M. Guerin Tours, Inc., P. O. Box 868, Port Huron, MI 48060, 313/987-7370.

Feb. 9 — "Investments for Retirement Income," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Feb. 14-15 – Practice management workshop, sponsored by MSMS and AMA, at Hyatt Regency Dearborn, contact: John Richards, MSMS headquarters.

Feb. 16-17 — Practice management workshop, sponsored by MSMS and AMA, at Hyatt Regency Dearborn, contact: John Richards MSMS headquarters.

Feb. 24-Mar. 3 — Michigan Doctors Study Club, Study/Ski Seminar, Vail, contact: Thomas R. Berglund, MD, c/o M. Guerin Tours, Inc., P. O. Box 868, Port Huron, MI 48060, 313/987-7370.

March 8-9 — Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Herbert Auer, MSMS headquarters.

March 24-31 — Michigan Doctors Study Club, Study/Ski Seminar, Snowmass, contact: Thomas R. Berglund, MD, c/o M. Guerin Tours, Inc., P. O. Box 868, Port Huron, MI 48060, 313/987-7370.

April 13 — "The Physician's Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

April 13 — Medical Aspects of Organized Athletics, Long's Convention Center, Lansing, contact: Herb Auer, MSMS headquarters.

May 1-3 — Auxiliary Annual Convention, Bay Valley Inn, Bay Valley, contact: Helen Schulte, MSMS headquarters.

May 5-7 — Annual MSMS House of Delegates meeting, Hyatt Regency Dearborn, contact: Dick Campau, MSMS headquarters.

June 15 — "Insurance Programs for Family Protection and Retirement Income," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Sept. 14 — "Legal Problems of Ending Medical Practice," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Oct. 12 — "Pre and Post Retirement Medical Care for the Physician and His Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Nov. 23 — "How Do I Know When to Retire?" presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Maternal & Perinatal Health Conference Update

The Planning Committee for the 1978 Maternal and Perinatal Health Conference, chaired by Bruce A. Work, Jr., MD, has developed an outstanding program for next sping's meeting at the Hyatt Regency Dearborn, March 8-9. Some of the subjects to be presented are neonatal intensive care outcomes, team approach to infant transport, in-birthing centers, fetal alcohol syndrome and perinatal dilemmas. The program is a cooperative effort of the Michigan State Medical Society; Michigan Section, Nurses Association, ACOG, District V; and the Perinatal Association of Michigan. Additional information will appear in future issues of *Michigan Medicine* and in *Medigram*.

Plans for Medical Aspects of Athletics Conference Underway

The Planning Committee for the 1978 Conference on Medical Aspects of Athletics has begun work on the program for this popular meeting held annually for physicians, coaches, trainers, and others involved in athletic programs in Michigan. The 1978 conference is scheduled for April 13 at Long's Convention Center, Lansing. Chairman of the Planning Committee this year is Edward M. Fugate, MD, of Muskegon. More information on the Conference will be published in upcoming issues of *Michigan Medicine* and *Medigram*.

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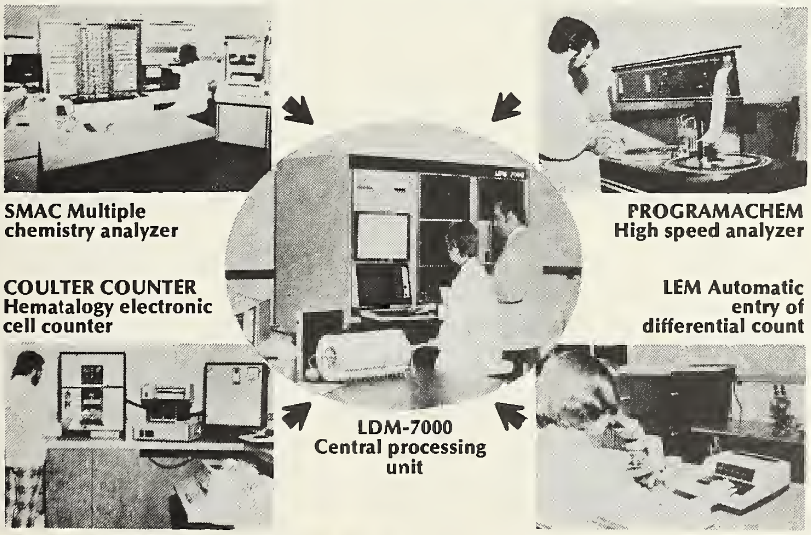
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Deaths

Robert A. Brown, MD
Trenton

Robert A. Brown, MD, Trenton, died Nov. 27 at the age of 63. Doctor Brown received his medical degree from the Wayne State University School of Medicine and was affiliated with Wyandotte General Hospital, Wyandotte, and Outer Drive Hospital, Lincoln Park. He was a member of the American Academy of Family Physicians and the American College of Emergency Physicians.

Herbert Cantor, MD
Franklin

Herbert Cantor, MD, 52, of Franklin, died Nov. 18. Doctor Cantor was a graduate of the University of Michigan Medical School. He was a member of the American College of Physicians and the American Society of Internal Medicine. He was a diplomate of the Board of Internal Medicine and a former vice-chief of staff at Grace Hospital.

George Conover, MD
Flint

George Conover, MD, Flint, died Oct. 31 at the age of 75. A graduate of the Wayne State University School of Medicine, Doctor Conover was a past president of the Saginaw Valley Academy of Ophthalmology and Otolaryngology. He was affiliated with Hurley, St. Joseph and McLaren hospitals.

Robert O. Dubpernell, MD
Detroit

Robert O. Dubpernell, MD, 61, of Detroit, died Sept. 25. Doctor Dubpernell, a graduate of Wayne State University School of Medicine with special attention to obstetrics and gynecology, was affiliated with Grace Hospital, Detroit.

Lambert J. Geerlings, MD
Fremont

Lambert J. Geerlings, MD, of Fremont, died Aug. 29.

George Louis LeFevre, Jr., MD
North Muskegon

George Louis LeFevre, Jr., MD, a surgeon from North Muskegon, died Nov. 19 at 82 years of age. A graduate of the University of Pennsylvania School of Medicine, Doctor LeFevre was a member of the American College of Surgeons and the International College of Surgeons. He was past president of the Muskegon County Medical Society, and was former chief of staff at Mercy Hospital. He received the Distinguished Service Award from the Muskegon County Medical Society for improving the relationship between medicine and the public.

Jules Shammas, MD
Ann Arbor

Jules Shammas, MD, Ann Arbor, died Nov. 8 at the age of 61. Born in Baghdad, Iraq, Doctor Shammas graduated from the French Jesuit University in Beirut, Lebanon. He was a specialist in neuro-psychiatry and was appointed assistant professor of psychiatry at the University of Michigan Medical School. Doctor Shammas was a member of the World Federation of Mental Health.

G. Howard Southwick, MD
Grand Rapids

G. Howard Southwick, MD, Grand Rapids, died Nov. 11 at 90 years of age. Doctor Southwick was former chief of staff and surgery at Butterworth Hospital. The Ontario native graduated from Wayne State University School of Medicine. He was a member of the American College of Surgeons and served as president of the Pennsylvania Railroad Surgeons Association. He was also a vice speaker of the House of Delegates of MSMS. He worked at Butterworth Hospital and was also on the courtesy staff at Blodgett Memorial Medical Center and St. Mary's Hospital.

Christopher H. Southwick, MD
Grand Rapids

Christopher H. Southwick, MD, 54, died Nov. 11. The Grand Rapids surgeon was a graduate of Harvard Medical School, Massachusetts. He was affiliated with St. Mary's, Blodgett Memorial and Butterworth hospitals, Grand Rapids.

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Study shows *Michigan Medicine* well read

By Judith Marr
Managing Editor

MSMS members reported very high interest in *Michigan Medicine* as they responded to the most recent readership survey of the MSMS journal.

The survey was conducted by Health Industries Research of Darien, Conn., for the Williams and Wilkins Company of Baltimore. The latter is the new national advertising sales representative for the 33 state medical journals affiliated with the State Medical journal Advertising Bureau of Oak Park, Ill.

Ten journals were selected to represent a wide range of geographic areas and population densities. They are from the states of Arizona, Connecticut, Indiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri and Texas.

Fifty-eight percent of *Michigan Medicine* readers who were surveyed completed usable forms for the tally.

Eighty percent reported they had read the July 1977 issue, the one used for test purposes. That was the second highest total.

Michigan Medicine was second highest of the 10 in the exposure potential for advertisements, a key factor in encouraging advertiserss to place ads in a journal.

Ninety-three percent of the respondents said they wish to continue to receive *Michigan Medicine*, the second highest total of the 10 journals surveyed, again.

The survey provided measurements of reading frequency, reading patterns, time of reading and attention paid to advertising. For the first time, journals were named specifically as they were surveyed.

The results in general are reported as follows by the SMJAB:

"State jounals are extremely well read. An average state journal is read by 79 percent of its audience each issue (*MM* — 82 percent). Ninety-six percent read at least one of every four issues (*MM* — 97 percent).

Michigan Medicine
JANUARY, 1978 • VOLUME 77, NUMBER TWO
JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

"The pattern of reading varies from journal to journal. The chance of a reader seeing an ad (exposure potential) ranged from a low of 37 percent to a high of 59 percent with an average of about 50 percent (*MM* — 58 percent, for the second highest).

The vast majority of readers of state journals "read articles of interest and look through remaining pages" (*MM* — 67 percent), or "read table of contents and articles of interest only" (*MM* — 18 percent).

Sixty percent of the readers say they pay attention to advertisements regularly or occasionally. This ranged from a low of 46 percent to a high of 74 percent (*MM* — 57 percent).

Readers, on an average, spend almost one-half hour with a state journal (*MM* — 24 minutes).

Nine of 10 readers want to continue receiving their state jornal (*MM* — 93 percent). And most physician's receive their journals in the office (*MM* — 81 percent).

MSMS journal tops in advertising revenue increases

Michigan Medicine compiled an outstanding record in advertising sales for 1977.

The MSMS journal had the largest increase in income from national advertising of the 33 state medical journals which are affiliated with the State Medical Journal Advertising Bureau of Oak Park, Ill.

National advertising sales for January through December, 1977 totaled $42,815.06. In 1976, total advertising sales were $33,632.66. The increase therefore was $9,182.40, or 27.30 percent.

The next biggest gain was registered by *Connecticut Medicine*, which increased its sales by $5,854.94, or 19.81 percent.

Part of *Michigan Medicine's* gain was due to an increase in advertising rates charged to companies in 1977. However, the increase also reflects the confidence and support advertisers give *Michigan Medicine* and its unique concept among state medical journals as a news-feature-opinion magazine for the state's physicians.

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ndications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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Please see preceding page for a summary of product information.

11 Michigan MDs need skills o present their views well n daily situations. To elp them gain those skills, SMS and the AMA are pre-enting three-day seminars n February and March on the rt of negotiations. The eminars are scheduled Feb. 1-23 at Long's Convention enter, Lansing, and March 8-30 at Hospitality Motor nn, Lansing. The seminars re especially recommended or physician leaders and omponent society executives ho have responsibility for egotiating activities. The rograms offer 12 hours of ategory I credit and are imited in enrollment to 60 ersons. Interested physi-ians should contact illiam Madigan, MSMS head-uarters, 517/337-1351.

* * *

ril 1 is the date when the ate's Medicaid program is be reorganized and con-lidated within the Michigan partment of Social Services. v. Milliken ordered the nsolidation in his State of e State message to improve ogram efficiency and ac-untability. Surveillance d utilization review func-ons, previously housed in e Department of Public alth, will be moved to DSS. e Medicaid bureau, within S now, will be elevated in ature to report directly the DSS director.

* * *

dicaid seminar schedules r February-June have been iled to all physicians in e Medicaid program. Two pes of meetings are fered: seminars designed r medical assistants who sire a review of basic re-rting procedures; and

(continued)

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 3 JANUARY 31, 1978

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Flash news item re: Blues

On Jan. 25 The MSMS Council reviewed the current controversies of Michigan physicians with Blue Cross/ Blue Shield of Michigan and offers the following three suggestions to Michigan MDs:

(1) Those physicians who have cancelled participation agreements effective Jan. 1 should consider remaining non-par, but may wish to continue participating on a per-case basis until end of negotiations March 15;
(2) That non-par physicians planning to no longer accept payments on a per-case basis consider per-case participation until March 15;
(3) That those physicians still considering the move to departicipate make their departicipation effective March 15.

It is hoped that between Jan. 1 and March 15 the BCBSM board will reconsider its decisions about differential in payments between par and non-par MDs.

The Council learned from MSMS counsel A. Stewart Kerr that (1) the hearing suit has been filed, (2) the psychiatric benefits suit was filed on behalf of psychiatrists, and (3) MSMS is contemplating yet a third suit in the near future. Details will follow in another Medigram next week.

MSMS task force moving on costs

The MSMS Task Force on Medical Care Costs is reviewing the 48 recommendations of the National Commission on the Cost of Medical Care. At its next meeting Feb. 22 the task force plans to divide into four groups to begin studying the Commission's full report, which was to be distributed at the AMA National Leadership Conference Jan. 26-28 in Chicago.

The MSMS Task Force has established liaison with the Michigan Hospital Association following appeals by a National Steering Committee promoting a grass-roots program of voluntary cost control. The national committee was formed in November by the American Hospital Association, American Medical Association and Federation of American Hospitals.

CAPSULES/continued

forums for experienced medical assistants interested in specific billing problems and additional clarification of detailed reporting procedures. With the continuing changes in the Medicaid program, it is suggested office assistants attend the meetings at least annually. Meeting schedules are available from MSMS or Medicaid (toll-free 1-800-929-2550).

* * *

Those U.S. Census Bureau questionnaires on physicians' business activities apply to all physicians and not just those incorporated as reported in the Jan. 13 Medigram. The forms are detailed, have been mailed to a selection of Michigan MDs. Law requires it must be completed.

* * *

The MSMS Medical Assistants group insurance program with Blue Cross/Blue Shield of Michigan is raising its premiums 16.4 percent as of Feb. 1. This is the group plan sponsored by MSMS for employees of MSMS members. Rates for all other MSMS-sponsored BCBSM programs will remain the same at least until contracts come up for review again.

Physicians affected by PA 339

The state's new program for treatment of persons incapacitated with alcohol took effect Jan. 15. Doctors, particularly those in emergency rooms, no face handling of "drunks" found in a public place and unable to function. Services reimbursed under Act 339 by the Office of Substance Abuse (OSAS) ar only for medical services related to detoxificatio for alcohol, social evaluation of the incapacitate person and referral services to other agencies whe deemed necessary. OSAS will not reimburse hospita for stays over 72 hours, nor for treatment of alcoholism. The program's purpose is to deal only wit persons who drink too much alcohol on a specific occasion, according to Maurice S. Reizen, MD, director of the Department of Public Health.

The statutory definition of incapacitated persons eligible for assistance under Act 339 is: "'incapacitated' means that a person, as a result of the use of alcohol, is unconscious or has his/her ment or physical functioning so impaired that he/she either poses an immediate and substantial danger t his/her own health and safety or is endangering th health and safety of the public."

Reimbursement for treatment should come from the patient or his/her insurer. Lacking other sources OSAS will pay physicians' bills when satisfied tha third party payor resources are unavailable. Phys cians must submit billings on Medicaid forms.

A detailed explanation and interpretation of the n program will be presented in the next Michigan Medicine.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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Managing Editor: Judith Marr

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ES UPDATE

progress of recent talks
ween Michigan physicians
the Blues is detailed in
s issue of Medigram. The
d of the physicians' negoti-
ons team calls for continued
orts in lead article on this
e. Pages two and three de-
l specific events, agree-
ts and legal activities in
onological order, with
ionale wherever possible
each development.

IS GATHERING OWN BLUES DATA

this issue went to press,
IS was tabulating a survey of
selective sample of 1,200
IS members on their reactions
the Blues' reimbursement
gram changes. The survey,
nducted by the MSMS Bureau of
onomics, is designed to pro-
le MSMS with its own data on
chigan physicians' attitudes
recent months re: the Blues.
sults will be published soon
Medigram and Michigan Medi-
ne.

2 NON-MEMBERS REPLY TO BLUES
ILING

cently, MSMS sent an informa-
onal mailing to Michigan MDs
o are not yet MSMS members.
e mailing suggested those
s join organized medicine
d help evaluate the Blues'
imbursement program changes.
of Jan. 17, MSMS had re-
ived 212 return cards indi-
ting interest. Each indi-
dual has received a member-
ip application, and
mponent societies in the
ysicians' home areas have
en alerted.

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 4 FEBRUARY 6, 1978

Michigan MDs holding firm in negotiations with Blues

A show of interest by Michigan physicians must continue in negotiations with Blue Cross/Blue Shield of Michigan, according to Donald K. Crandall, MD, Muskegon, chairman, MSMS Committee on Negotiations. Negotiators now are addressing major issues, says Doctor Crandall. BCBSM representatives have told the doctors' negotiating team they will take to their Board doctors' demands that the Blues eliminate payment differences to par and non-par doctors in new Blues programs. The BCBSM board next meets March 3. Michigan MDs, in turn, have agreed to develop an acceptable alternative to the Blues' proposed target limitation of expenditures (TLE) method for cost control.

A key to the success of the negotiations so far, Doctor Crandall emphasizes, has been Michigan physicians' support in declaring their intent to departicipate with the Blues in protest of the Blues' changes. Physicians now are extending their deadline for negotiating from Jan. 1 to March 15. "The campaign still is going on," declares Doctor Crandall. "We are not taking a soft line, as the Blues still are trying to get more doctors to participate."

The MSMS Council underlined the importance of MDs' continued resistance to the Blues' changes at its regular meeting Jan. 25. The Council suggested (1) Michigan physicians who have cancelled participation agreements effective Jan. 1 should consider remaining non-par, but may wish to continue participating on a per-case basis until conclusion of negotiations March 15; (2) Non-par physicians planning to no longer accept payments on a per-case basis consider per-case participation until March 15; (3) Physicians still considering the move to departicipate write BCBSM now and make their departicipation effective March 15.

Doctor Crandall says evidence of increasing interest is important in case negotiations don't satisfy

(continued on back page)

Chronological backgrounder on Blues talks of past week

Oct. 26, 1977--MSMS House authorizes legal activity

The MSMS House of Delegates in special session Oct. 26 authorized The MSMS Council, in consultations with legal counsel, to undertake on behalf of MSMS members and their patients, legal activities, including lawsuits expeditiously and in such courts as they deem appropriate. A dues increase of $35 per member was authorized to enable MSMS to meet legal costs. Suits since have been filed by MSMS against certain BCBSM programs, as the Blues have declared these programs fait accompli, out of their hands, and non-negotiable.

Dec. 23, 1977--Otolaryngology Suit

Legal counsel filed suit at the request of two otolaryngologists (John W. Grigg, MD, Bay City, and Dieter Wendling, MD, Mt. Clemens) in Federal District Court, Detroit, against BCBSM, General Motors Corporation, Ford Motor Company, Chrysler Corporation and the UAW over provisions of the new Hearing Care Program which took effect Oct. 1. The suit alleges the Hearing Care Program (1) illegally interferes with and deprives the plaintiff physicians of their freedom to practice medicine and their patients' freedom to select their own doctor, (2) coerces UAW employees to be treated only by formally participating doctors and coerces physicians to formally participate in the program, (3) violates the Equal Protection and Due Process clauses of the U.S. Constitution, and (4) violates federal and state anti-trust laws and the Michigan Insurance Code.

Dec. 28, 1977--MSMS/BCBSM Meeting

BCBSM representatives met Dec. 28 with MSMS representatives and negotiating committee members to air differences over BCBSM's differential in payment to participating and non-participating doctors and the Blues' proposed TLE program. BCBSM reps said they designed the new physician reimbursement program to increase formal participation in their programs. BCBSM indicated they have not been successful in increasing participation. They said the per-case option is not as acceptable as formal participation because subscribers feel they are not assured of full coverage.

After three and a half hours of delibe-ations, MSMS essentially agreed to develop an effective cost containment program as an alternative to the TLE. BCBSM leaders agreed to seek BCBSM Board commitments to eliminate the payment differentials between par and non par physicians.

While MSMS representatives were able t commit themselves regarding cost containment because it is MSMS House of Delegates policy, BCBSM representativ only were able to commit to reconside ation of payment differentials.

Dec. 28, 1977--Negotiating Committee Meeting

Immediately after the meeting with BC M the physician representatives met wit the negotiations committee to discuss alternatives. The committee decided then to recommend to The Council that it wait until BCBSM's next board meet March 3 to see if it follows through its commitments. Although there are clear-cut assurances at this time, th Committee on Negotiations feels Michi physicians have made progress in resolving the major issues.

Jan. 19, 1978--Letter of Understandin to BCBSM

The following letter of understanding was sent to John C. McCabe, BCBSM pre-ident, by Donald K. Crandall, MD, cha-man, MSMS Committee on Negotiations:

"Following our meeting of December 28 we both need a clear understanding of what transpired. These are the point we agreed to carry forward and will present to The Council on January 25.

iere were two key issues to be re- lved:

(1) MSMS commitment to develop an ective cost containment program as alternative to the TLE.

(2) BCBSM commitment to apply all pects of the physicians' reimburse- nt program equally to participating i non-participating physicians.

iile our representatives were able to nmit MSMS regarding cost containment cause it is a stated policy of the ise of Delegates, BCBSM representa- ves were only able to commit to re- isideration of the physician payment fferential by the appropriate commit- es and the Board.

SMS agreed to delay the call for plementation of a new claim form un- l the Blue Cross/Blue Shield of Mich- an Board could respond to its commit- nt. Because of the structure of 3SM Board committees and scheduled etings, MSMS granted BCBSM until its rly March Board meeting to make its nmitment.

lthough some discussions were carried : regarding 'non-aggressive attitudes' l legal actions, MSMS took the posi- on that it would not withdraw the earing' suit and would continue other gal actions, specifically with regard areas that were 'non-negotiable.'

SMS also stated it would continue to licit non-participation by Michigan ysicians to be effective after a new adline.

CBSM and MSMS also agreed to improve tual communications to insure better ysician input into the BCBSM cision-making process.

iese items will be discussed at future etings pending the BCBSM Board proval of its commitment to eliminate e differential in payments to partici- ting and non-participating doctors."

n. 19, 1978--Psychiatric Suit

IS legal counsel, at the request of e Michigan Psychiatric Society, filed suit on behalf of two Michigan psychiatrists (Douglas A. Sargent, MD, Detroit and Morris Weiss, MD, Southfield) and two psychiatric patients. The suit was filed in Federal District Court, Detroit, by Kerr, Wattles and Russell, against BCBSM over a recent cutback in out-patient psychiatric benefits. The suit alleges the cutback in out-patient psychiatric benefits in a Master Medical Plan (1) discriminates against out-patient care as a mode of psychiatric treatment, (2) forces patients receiving out-patient care to enter in-patient facilities, driving up health care costs, (3) violates the Equal Protection Clause of the U.S. Constitution by forcing the termination of out-patient treatment, (4) causes patients to suffer the unnecessary hardship of having to leave their families and jobs and be placed in in-patient facilities at great expense, (5) interferes with and disrupts the doctor/patient relationship in violation of the Blues' Enabling Act, (6) violates doctor/patient rights to privacy, and (7) breaches various applicable employer/ BCBSM contracts which plaintiffs, as third party beneficiaries, have relied upon.

Jan. 25, 1978--Negotiations Committee Report to The Council

Doctor Crandall told The MSMS Council Jan. 25 of a phone conversation that day with a BCBSM officer. Doctor Crandall reported BCBSM at this time would not commit its board to total parity between par and non-par doctors, though there was the possibility of more equal reimbursement to non-par doctors. MSMS argues any disparity in physicians' payments penalizes the patient/subscriber who obtains services from non-par physicians.

Doctor Crandall reviewed for The Council three economic incentives of the Blues' reimbursement policies effective Jan. 1 which are offered now just to participating doctors. The physicians' negotiations team is working to get all three for all physicians including non-par. They are: (1) Adjustment of fee profiles (Current non-par physicians who sign formal participation agreements between now and April 1, 1978 also will receive this automatic adjustment),

BOARD OF MANAGERS TAKES THREE ACTIONS

The MSMS Board of Managers on Jan. 25: (1) chose new investment counselors for MSMS funds effective Jan. 31. The new counselors, who are Sabl Associates of Los Angeles, Oppenheimer Capital Corporation of New York will be monitored periodically in the initial four months to be sure MSMS investment objectives are maintained throughout the changeover; (2) Proceeded with plans for a 20,000 sq. ft. building at MSMS headquarters to expand facilities. December is the target for occupancy. Architects are O'Dell, Hewlett and Luckenbach of Birmingham. Portions of the building not required by MSMS at this time will be leased to carefully-selected tenants whose business is compatible to MSMS activities; (3) Continued serious investigation of a physicians pooled trust pension program as an important MSMS member benefit. All three of the board of managers' actions were approved later that day by The MSMS Council.

Informational Background/continued from page 3

(2) Cumulative carry-over of annual customary fee increases (Currently the physician receives the allowable fee increase only for the year in which he files, or loses the allowable increase when he fails to file. Under the new policy, participatin physicians would be permitted to carry over all allowable increases for the year(s) in which they do not file for an increase.), and (3) A statewide screen (Existing area/specialty differentials woul be eliminated Jan. 1, 1978 for all participating physicians. Area and specialty differentials would be maintained for non-par physicians.)

Negotiations/continued from front page

physicians' interests by March 15. "Physicians ma wish now to write their letters of intent to departicipate effective March 15, to encourage settleme of physicians' and Blues' differences," he says. He emphasizes should agreement not be reached by that time, physicians can intensify their efforts influence the Blues then.

MSMS Council highlights

The MSMS Council at its regular meeting Jan. 25: (1) Made three suggestions to Michigan physicians re: the Blue Cross/Blue Shield of Michigan (see accompanying articles); (2) Requested the MSMS Negotiations Committee to investigate with the Insurance Commissioner and the BCBSM board the possibility of BCBSM becoming an indemnity company; (3) Re-elected C. Allen Payne, MD, to a one-year term on the MSMS Board of Managers, and elected Arthur A. Ulmer, MD, to a one-year term; (4) Requested MSMS Legal Counsel A. Stewart Kerr to meet with legal representatives of the Michigan Psychoanalytic Society to discuss concerns with recent BCBSM payment policies for out-patient psychiatric care.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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HEALTH CARE PLANNING

Michigan Medicine

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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BILL MITCHAM

The Plan and Policy Development Committee of the Statewide Health Coordinating Council plays a key role in Michigan's health care planning. See pages 73-76, and 124 for special section on health planning.

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Special Section:

Health care planning in Michigan

Part I: What's happened since HSAs were created

By Sherry Wellman
MSMS Staff liaison
for government agencies

It was Jan. 4, 1975 when President Ford signed into law the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). Heralded by its supporters (and feared by its opponents), the Act was called the most important single piece of health legislation enacted by Congress and was designed to restructure the entire health delivery system in the United States.

That was three years ago. It is now timely to assess how far the health planning process has or has not progressed. As originally envisioned, the process would work something like this: a National Health Planning and Development Council would be appointed which would issue broad guidelines for national health policy. These guidelines would be used by the local health systems agencies to prepare health systems plans. The HSA plans would be used by the Statewide Health Coordinating Council to prepare a state health plan. From there, both HSAs and the SHCC would set out to implement their respective plans to improve the delivery and quality of health care and at the same time contain related health costs.

A look at how the process is actually working reveals some trouble spots. It was not until Sept., 1977 that HEW published proposed national guidelines for health planning called for by the 1974 Act. The guidelines were to be the initial statement on a national health policy from which the state and local agencies took their cues. HEW was supposed to consult with the National Health Planning and Development Council and other professional organizations prior to issuing the guidelines, but the Council had just been appointed. In addition to the late date and procedural problems, the guidelines provoked *thousands* of letters criticizing their content.

The most strenuous objections were directed at the proposed standards which could force the closing of vital small rural hospitals or parts of hospitals and the central question of whether health planning decisions were going to be made at the local level or by HEW. Individual Congressmen were swamped with letters and an alarmed House of Representatives unanimously passed a resolution stating that the guidelines "should include sufficient flexibility to allow a health systems agency to recognize special characteristics in rural areas." HEW has assured Congress that the guidelines will be revised.

The controversy over the guidelines has caused problems for HSAs which are required to prepare health systems plans after consideration of the national guidelines. The fact that HEW did not have guidelines in place has not exempted the HSAs from meeting the deadline for submission of the plans.

In Michigan, four of the eight HSAs have had their health systems plans approved by the Statewide Health Coordinating Council, and the SHCC already is in the process of developing the state health plan which is supposed to be derived from the HSA plans.

Perhaps the most interesting thing to be learned by the comparison of the planning process as envisioned and what is actually happening is that the planners are committed to getting on with their mission — whether or not they follow the plan prescribed in the law. ◥

Health Service Area	*Health Systems Agency Information*	*MDs Serving on HSA Boards*
1	COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN 1200 Book Building, Detroit, MI 48226 Terence E. Carroll, Exec. Dir. (313) 964-6950	James D. Fryfogle, MD, Southfield William O. Mays, MD, Bloomfield Hills Leland C. Brown, MD, Mt. Clemens John Gronvall, MD, Ann Arbor Joseph Montante, MD, Orchard Lake Billy Baumann, MD, Pontiac
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Part II: How Michigan planning process is organized

Health Planning Abbreviations and Acronyms*

AIP — annual implementation plan; a plan which requires health systems agencies to prepare or update annually, specifying, describing how to implement, and giving priority to, short-run objectives which will achieve the long range goals of the agency, detailed in its health system plan.

HSA — health systems agency; a health planning and resources development agency designated for a health service area; functions include preparation of a HSP and an AIP, issuance of grants and contracts, the review and approval or disapproval of proposed uses of a wide range of Federal funds, and review of proposed new and existing institutional health services; in Michigan there are eight HSAs.

HSP — health systems plan; a long range health plan prepared by a HSA for its health service area specifying the health goals for the area; to be prepared after consideration of national guidelines issued by HEW and study of the characteristics, resources and special needs of the area.

OHMA — Office of Health and Medical Affairs; in Michigan the designated state health planning and development agency (SHPDA).

SHCC — Statewide Health Coordinating Council; a state council of providers and consumers (who shall be in the majority); generally supervises the health planning work of the SHPDA (OHMA); reviews and coordinates the plans and budgets of HSAs; annually prepares a state health plan from the HSA plans and the preliminary plans of the SHPDA (OHMA).

SHP — state health plan; an articulation of goals; priorities, and strategies to guide the planning and management of state health delivery programs, the development and implementation of state health policy, and the coordination of health delivery systems throughout the state; the plan is developed by the SHPDA and the SHCC under the provisions of P.L. 93-641; the plan is derived from regional health systems plans which have been coordinated and possible modified to meet health needs of the state. (This definition written by OHMA.)

SHPDA — state health planning and development agency; prepares annual preliminary state health plan and state medical facilities plan; serves as the designated review agency for purposes of section 1122 of the Social Security Act and administers the certificate of need program; in Michigan the SHPDA is the Office of Health and Medical Affairs (OHMA).

**Definitions taken, in whole or in part, from* A Discursive Dictionary of Health Care, *prepared by Congressional staff for use of the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, U.S. House of Representatives, February 1976, U.S. Government Printing Office, Washington.*

By Andrew D. Hunt, Jr., MD
East Lansing

The State Health Coordinating Council (SHCC) and its corresponding governmental agency, the Office of Health and Medical Affairs (OHMA), head current Michigan federal-state cooperative efforts in health planning.

While the responsible bodies for planning at the community level are the Health Systems Agencies (HSAs), the SHCC is mandated to integrate the Health System Plans (HSPs) as developed by the HSAs, meld them so they are compatible with needs perceived at the state level; thus to develop a state health plan.

Such a plan, once developed, must be reviewed and revised at least annually. Other functions of the SHCC include:

1) Review of budgets and applications submitted by HSAs for planning grants and grants for area services development funds.
2) Advise OHMA (based in Office of Management and Budget in the Executive Branch) on the performance of its functions.
3) Review annually and approve or disapprove any state plan or application to the Secretary of HEW as a condition to the receipt of any funds under allotments made to states under
    a) The Public Health Services Act,
    b) The Community Mental Health Centers Act,
    c) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

SHCC an eclectic group

The multiplicity of tasks and responsibilities willed upon the SHCC by its creator, namely the Congress through Public Law 93-641, derives from the Congressional intent to combine four previous planning and funding initiatives into one. These were:

1) The Hill/Burton Act.
2) Categorical health related program planning, such as drug abuse and alcoholism.
3) Public Law 89-749 (Comprehensive Health Planning).
4) Regional Medical Programs.

The SHCC, then, is burdened with an eclectic and highly diversified set of functions sometimes forcing technical judgments which seriously extend the capacity of such a group of volunteers. Both close collaboration with the OHMA staff and well-conceived organizational structure are essential to success.

The OHMA staff, with Jay Endsley as director, is highly competent, with several members having lived through a significant portion of the days of the previous Comprehensive Health Planning program. Its tasks are, if anything, more diverse and burdensome than those of the SHCC. In addition to implementation of 93-641, OHMA has multiple responsibilities as a major health agency of state government and as an advisor to the governor on many health issues.

The SHCC has 53 members, each appointed by the Governor. Consumers are the majority. Not less than one-third of the provider members are direct providers of health care. Thirty-two of the members were selected from the eight HSAs of Michigan, and the remainder were selected "at large." The chairperson and vice-chairperson are elected annually, for one-year terms not to exceed three consecutive terms.

The SHCC elects an executive committee which primarily has a steering function, with all its decisions subject to approval by the SHCC.

Standing Committees are:

1) The By-Laws-Nominating Committee.
2) The Review Committee — responsible for assisting the SHCC in reviewing HSA applications for planning and other funds, reviewing HSA budgets, and carrying out the annual review of plans submitted to HEW as described in (2) above.
3) The Plan and Policy Development Committee, currently chaired by Daniel Kehoe. This group is now the most active, as it assists the SHCC in reviewing the health system plans for all eight Michigan HSAs and their applications for permanent designation, and in preparing the state health plan. This is an arduous and probably thankless task involving the identification of health priorities as seen by both the SHCC and the HSAs. Conflicts are regular and predictable, and the forging of the first state health plan is underway, via diligent hard staff work at HSA and OHMA levels, and intense, tumultuous, and contentious meetings of HSA boards, Plan and Policy Development Committee, and SHCC alike.

A chance to help

The process is indeed complex and cumbersome, but really has a chance of helping to alleviate the inefficiencies, inequities, and redundancies of the present "non system" through citizens' participation in collaborating with, rather than being dominated by, the federal government. With "cost containment" in the national limelight, it is not surprising that this issue colors the entire proceedings, causing a great preoccupation with hospital utilization and abatement of costs through decreasing the number of hospital beds.

Cost containment as an end in itself clearly could wreak great mischief if not combined with some concomitant definition of an acceptable quality of health care which is within society's means. Planning at that level of sophistication could come once the current crunch has been endured, and will require intense ethical as well as economic and medical considerations.

In any case, continued interest and involvement of our profession is utterly essential as this process of planning proceeds with increasing specificity to identify the role of medicine in the health of the state and its various communities. We are discovering, sometimes to the surprise of many, that maintenance and achievement of health is indeed a collaborative enterprise involving responsible behavior by individuals, communities, and the great society itself of which medicine is an important, but by no means dominant, part.

Doctor Hunt is chairman, Statewide Health Coordinating Council

MDs Appointed to Statewide Health Coordinating Council

D. Bonta Hiscoe, MD, Lansing, board member of Michigan Mid-South HSA
Andrew D. Hunt, MD, East Lansing, chairman of SHCC
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Contributors to this special section:

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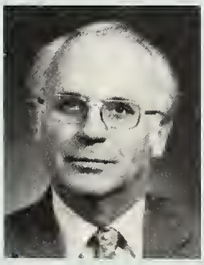


Doctor Hunt

Doctor Fryfogle

Ms. Wellman

Part III: Labor sees two goals: one is physician accountability

By Paul Massaron
Madison Heights

The typical way in which many places around the country convey the importance of health planning is through a litany of platitudes about rational planning, cost containment, accessibility to health care and quality health care. Many people active in Health Systems Agencies (HSA's) or the Statewide Health Coordinating Council (SHCC) have a tendency to take this tack. The litany usually is delivered in a host of technical terms and bureaucratic abbreviations. Some of those who speak are, of course, programmed by "health planners" who sometimes suffer from too much education and not enough living as normal consumers of health services in this society.

On a very practical basis, one can look at two of the "health system goals" (one a subgoal) under consideration by the Statewide Health Coordinating Council and develop an understanding of what some providers and health planners have in mind for consumers of health care — as a method of cost containment. Both items express a philosophical support for "consumer cost-sharing" for necessary health care services.

Cost containment addicts

The proponents of the "cost-sharing" for necessary health care services idea, under which about 10 percent of a person's income (not including insurance premiums) would be taken for out-of-pocket payments in co-payments and deductibles, are the real "cost containment addicts." They seek to take from the average consumer, already racked by inflation, additional funds (or deny needed health care) under the guise that costs will be contained. The average consumer has no control over the health care non-system. These "cost containment addicts" want their "fix" at the expense of those who have no control while avoiding real concrete action directed toward those who control the health care non-system and profit from it.

Even worse, they believe that the sword of economic pressure on the individual consumer will restrain utilization — which is not substantiated by any major study conducted in North America in the last 20 years or by any major programs that have had "cost-sharing" features.

Provider accountability

If the consumer's share is high enough, a short-term reduction in costs will probably occur, but this often leads to use of more expensive services for a longer duration at a future point. The major issue is provider accountability; and consumers will not permit the application of a consumer penalty for what are basically provider decisions.

A favorite theme of those who deny the serious problems in America's health care system and hence reject meaningful solutions is that the patients are largely responsible for the problems. They demand too much, and if they had comprehensive coverage, their demands would be well beyond the capacities of doctors, hospitals and other health providers.

The worn-out suggestion of cost-sharing does not go to the source of health care inflation. The consumer has a minimal control over decisions about the use of hospitals and most other services. These decisions are made primarily by doctors.

- Consumers do not admit themselves to the hospital or arrange for their discharge.
- Consumers do not decide to stay in the hospital for an inordinate amount of time.
- Consumers do not write prescriptions for themselves.
- Consumers do not order an array of unnecessary tests and services for themselves.
- Consumers do not decide to build unnecessary hospital beds.
- Consumers do not decide to keep beds on line that should be closed down.
- Consumers do not permit the continued existence of hospitals that should be closed.
- Consumers do not decide to acquire additional expensive equipment already available within the community.

The Medicare Program has had substantial cost-sharing through increasing co-insurance and deductibles. Although the elderly are today paying more out-of-pocket for health care than they were before Medicare was passed, there has been no decrease in the program's rising cost.

Right now, a Chrysler worker pays about $1 per hour from his collective bargaining dollar for health insurance for himself and his family. If cost-sharing proponents believe he can absorb another $1,200 in out-of-pocket costs, then they do not understand what it costs to live in this society.

Cost-sharing a barrier

Cost-sharing through deductibles and co-insurance mechanisms does not adequately or appropriately contain health care costs. The idea is based on mistaken notions about the nature of consumer and provider behavior in the health care system. Its principal effect is to transfer costs to patients from third-party payers. It has little impact on the use or cost of hospital services, the area of the most severe recent cost increases. Cost-sharing constitutes a barrier to care for more disadvantaged groups and to those in greater need of care. Finally, a simplistic focus on cost-sharing distracts from the more basic and politically difficult measures which must be taken to influence providers to more appropriately use health care resources.

One of the goals of the State Health Plan should be: Every family or unrelated individual should be able to consume necessary health care services without incurring any significant out-of-pocket expenses including out-of-pocket premiums.

Further, the thrust of other goals should be directed at provider accountability.

Mr. Massaron is international representative for the United Auto Workers. ◥

If we listen, the ancients have words for us

Vernon V. Bass, MD
MSMS president

This month, I'd like to give my column to several distinguished gentlemen whose noteworthy quotations follow:

Hippocrates, 460 B.C. — 375 B.C.

The Oath: "I will follow the system of regimen which, according to my ability and judgment, I consider for the benefit of my patients and abstain from whatever is deleterious and mischievous. With purity and with holiness I will pass my life and practice my art."

On Ancient Medicine: "I would give great praise to the physician whose mistakes are small, for perfect accuracy is seldom seen.

"The physician must have two special objects in view . . . to do good, and to do no harm.

"Life is short, and art is long; the crisis fleeting, and decision difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and the externals cooperate."

Aristotle, 384-322 B.C.

On Principle: "The end cannot be a subject of deliberation, but only the means; nor indeed can the particular facts be a subject of it."

Rousseau, Jean Jaques, 1712-1778 A.D.

"Force made the first slaves, and their cowardice perpetuated the condition."

Plato, 428-348 B.C.

"The slave-doctor prescribes what mere experience suggests, as if he had exact knowledge, and when he has given his orders. Like a tyrant, he rushes off with equal assurance to some other servant who is ill."

Kant, Immanuel, 1804-1924 A.D.

"A contract by which the one party renders his *whole* freedom for the advantage of the other, ceasing thereby to be a person and consequently having no duty to observe a contract, is self-contradicting, and is therefore of itself null and void."

Locke, John, 1632-1704 A.D.

" . . . the end of law is not to abolish or retain, but to preserve and enlarge freedom."

Socrates, Exact birth date unknown, executed in 399 B.C.

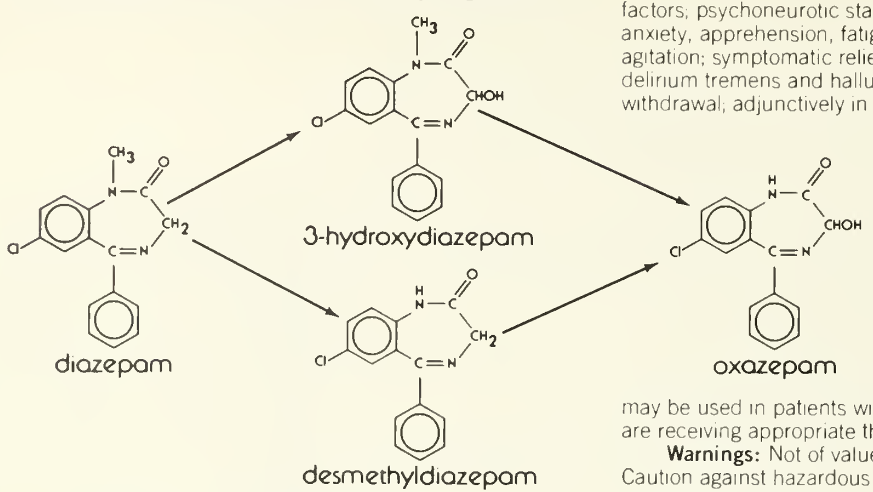
"Justice is concerned not with the outward me, but with the inward, which is the true self and concernment of man; for the just man does not permit the several elements within him to interfere with one another, or any of them to do the work of others — he sets in order his own inner life, and is his own master and his own law, and at peace with himself . . . one entity, temperate and perfectly adjusted to nature."

Tawney

"If a man has important work to do, and enough leisure and income to enable him to do it properly, he is in possession of as much happiness as is good for any of the children of Adam."

Thank you, gentlemen. Your intelligence is fitting in today's climate. ◥

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) Ⓘⓥ

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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Nutley, New Jersey 07110

". . . if the Michigan State Medical Society continues to ignore these critical issues."

On several occasions in the last two years or so, we have discussed the issues of surplus hospital beds and overutilization of hospital care in Michigan. As a physician and active member of the Michigan State Medical Society, I continue to be concerned at the apparent reluctance of the society's officers, Council and House of Delegates to recognize and deal with these very important, though controversial issues.

On Jan. 24, 1977, Rep. Raymond Kehres and Sen. Jerome Hart spearheaded the convening of a task force meeting on Medicaid issues. The purpose of the meeting was to discuss ways in which the State might come to grips with the immediate need for cost containment in the Medicaid program specifically and the health care delivery system generally. The attention of the task force quickly focused on the above issues since the elimination of surplus hospital beds and overutilization of hospital care had the potential for very significant cost savings.

As a result of the task force efforts, Reps. Kehres and Larsen introduced HB 4491 in April 1977. The bill was drafted to provide a mechanism for eliminating some 6,000 to 7,000 surplus beds from Michigan hospitals.

Initial opposition to the bill from the hospital industry and others affected by the bill prompted the task force and a special subcommittee to continue their efforts through the summer and early fall to resolve areas of difference. It is my understanding that this has been accomplished, at least to the satisfaction of the task force, and that in all probability a substitute for HB 4491 will be introduced in the near future.

The Department of Public Health, as stated earlier, supported the original version of the Bill and will also support the most recent draft prepared by the task force should it be introduced.

To my knowledge, there has been no practicing physician input to the bill to date!

I do not believe there can be any legitimate question as to the very substantial surplus of beds in Michigan hospitals nor that there is a significant overutilization of hospital care in many of the State's 77 health facility service areas.

Two or more years ago, a task force was convened by the Office of Health and Medical Affairs with the support of the Department of Public Health to develop an acute care bed need methodology for the State. The methodology was reported more than a year ago and after careful consideration was adopted by the State Health Facilities Commission with minor changes. In general, the methodology calls for a maximum use rate of 1,000 days of hospital care per 1,000 population per year. With adjustments for obstetric utilization and the percentage of elderly in the service area population, the maximum rate will approximate 1,075 days of care per 1,000 population per year. (This may be slightly higher in the upper portion of the lower peninsula and the Upper Peninsula because of the introduction of a compensating factor for "rurality".) This is substantially under the current State rate of 1,179 days of care and very much under the use rates for many of the State's health facility service areas.

The following use and discharge rates for selected health facilty service areas are excerpted from 1975 data.

AREA	HOSPITAL USE RATE	HOSPITAL DISCHARGE RATE
STATE	1179.97	149.93
Grand Rapids	844.64	116.95
Escanaba	869.59	148.68
Lansing	925.35	129.38
Ann Arbor	979.34	109.45
Kalamazoo	996.12	132.14
Marquette	1016.67	133.85
Mt. Clemens	1089.40	149.73
N.E. Detroit	1126.92	140.71
Pontiac	1134.16	147.55
N.W. Detroit	1161.57	133.82
Dearborn-Wyandotte	1166.11	144.21
Wayne	1178.79	146.46
Bay City	1295.98	178.10
Flint	1367.03	175.00
Battle Creek	1435.84	195.69
Sault Ste. Marie	1440.28	138.71
Central Detroit	1497.93	158.54
Hancock	1644.52	136.76

While the above statistics are nearly two years old, it is anticipated that there will be little change in the State Plan revision to be published in the near future. (The State Plan revision will be based on 1976 hospital utilization data). Most important, the statistics show that hospital utilization, more consistent with accepted standards, is possible in both urban and rural areas. It is also of interest to note the statistics regarding the hospital discharge rate for the respective service areas which are correlated with a high hospital use rate.

Physicians play a major role in determining who will or will not go to the hospital for care. Thus, physicians, particularly in areas of significant overutilization, must bear a major responsibility for corrective action. This responsibility probably will not be exercised in the most appropriate or effective manner if the Michigan State Medical Society continues to ignore these critical issues. On the other hand, it is likely that something will be done before long to resolve the above issues with or without physician input.

Sincerely,

Hermann A. Ziel, Jr., MD
Chief, Michigan Bureau
of Health Care Administration

(Editor's note: Michigan Medicine considers the overall issues of health care planning through special articles on pages 73-76 and 124 in this issue.)

Even brilliant surgery can be complicated by infection...

ANCEF® is effective in post-surgical infections*

- *Broad coverage of the major areas of post-surgical infection due to susceptible organisms. See Indications on next page.

- High Levels Present in Tissues and Fluids†
Ancef® achieves high concentrations in bone, synovial fluid, skin and soft tissues (such as pleural fluid, peritoneal fluid and lymph nodes). Ancef® is also excreted in a microbiologically active form in urine.

- High and Prolonged Serum Levels
A single 1 gram IV injection produced a mean peak concentration of Ancef® of 190 mcg/ml in healthy adult volunteers. After 4 hours, levels of 16.5 mcg/ml were still present.

- IM or IV Dosage Flexibility
The same dosage schedule can be used for both IM and IV administration.

- Well Tolerated
Most frequently reported adverse reaction is pain on injection. Please see next page for a complete list of reported adverse reactions. **Use with caution in patients with penicillin or other allergies.**

Please see next page for a brief summary of prescribing information, including indications, contraindications, warnings, precautions, and adverse reactions.

†Data on file, SK&F Medical Department. Tissue penetration is regarded as essential to therapeutic efficacy, but specific antibiotic tissue levels have not been directly correlated with specific therapeutic effects.

Smith Kline &French Laboratories
Philadelphia, Pa.

ANCEF® IV IM
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)

Injection: 250 mg, 500 mg, and 1 gram vials

SK&F
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ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg, 500 mg, and 1 gram vials

Most infections can be treated with 500 mg. or 1 gram of 'Ancef' every 8 hours.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

Respiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus.*

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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Costs should be conserved by high standards, not denial

By Yong Hwa Park, MD
Howell

Economic waste by unnecessary medical care, and large expenditures for complicated and challenging medical cases are two entirely different issues, and should therefore be viewed in a different context. Yet the difference in these two issues have been confused by many, especially non-physician professionals.

One could easily be misled to conclude that depriving medical care from a few complicated cases would greatly add to medical cost conservation, and therefore could be justifiable.

It is understandable that one is bothered by the findings of a survey by the University of Chicago Center for Health Administration Studies which reveals one percent of the users of medical service account for 25 percent of the medical expenditures. But we have to understand that "the one percent of the medical users" really need the concentrated medical care, and you and I might belong to that one percent. It must be perceived that assigning 25 percent of medical resources to the one percent of the medical users is very different from giving 25 percent of resources of food and gasoline to a specially privileged one percent of people. Rationing of medical service is neither necessary nor economical.

Physicians have sense of economy and reality

Doctors are not psychopaths. A physician does not give a treatment to his patient unless he is reasonably sure the potential advantages of the proposed treatment outweigh any potential disadvantages. When there is more advantage than disadvantage, the net benefit cannot be measured by units of dollars. Most physicians are not foolish and have a sense of economy and reality. Generally, physicians perceive the impossibility, impracticability, and hopelessness of a particular medical situation except for rare exotic cases such as the case of Karen Ann Quinlan. Most medical expenditures made at the discretion of physicians are well spent.

It has been said that the spending for medical service for complicated cases becomes a poor investment, and it has been suggested that human welfare could be improved by the allocation of financial resources to other purposes, even by denying some patients the chance to live. In my opinion there is no way of spending human effort more valuably than in the care of the sick (even in extreme situations).

It must be appreciated that the small group of patients who use costly medical resources, contribute tremendously to the progress of physicians' knowledge and skill which, in turn, improve the care for other patients. In other words, the "one percent of sick people" really help to maintain high medical standards, so that other ill people with less difficult problems do benefit.

Cap on expenses no guarantee of improvement

The idea of diverting the calculated expenditure from the medical care of the "one percent of patients" and applying the same expenditure to the general public for overall increased benefits may be applicable for veterinary practice but not for human medicine.

The idea of putting a strict limitation on medical expenditure in a given year has also been proposed on the ground of afore-mentioned illusory ideas, which in turn makes it impossible to avoid a decision that saves some and condemns others with complicated problems.

Doctor Park

It should be pointed out that the idea of a strictly predefined limitation is wrong to start with because of the reasons discussed earlier. Putting a cap on medical expenses would be inevitable for a government planning a budget for the coming year, however the government should have flexibility in this particular sector of economy if there is interest in more than a simple political show. In other words, this "cap" can be more or less a political necessity but is not at all a requisite for better medical care and does not contribute to the welfare of the people.

One would agree that the human resources used for the care of ill people have been well spent and have been one of the wisest investments of mankind.

The important issue in the medical economy has to be whether the medical care in question is necessary or unnecessary, rather than whether the needed treatment is a simple or a complicated one.

Medical expenditure should be conserved by high standards of preventive and therapeutic medicine, but not by denying necessary care to any patient.

(References are available from the author.)

These are gratifying times for family practice

By George A. Dean, MD
Southfield

Dialogue and debate exist as to who can best serve the family health care needs of American citizens. Criticism of family practice has been varied. "It is a fad." "Its role is without academic content." "It cannot be defined." "The role will prove to be professionally unfulfilling, and its practitioners won't last." Many of these comments have been dispelled by experience.

The election is not over, but the early returns suggest a trend in favor of family practice. This trend has occurred because of several factors: first, it is just one manifestation of a turning away in many areas of American life and thought from over-specialization; secondly, the family physician's compassion and concern is a constant over a period of time, which assists the patient in freeing himself from diseases of the soma and the psyche.

I acknowledge that family physicians have no monopoly on humanistic and personal care, and the best doctors throughout history have practiced the art with consummate skill. But family physicians have attempted to teach and extol the humanistic approach to the practice of medicine as an essential element of its curriculum.

However compassionate, and however great the physician's psychological orientation, the average subspecialist's main professional concern is with an affiliate organ system. He is not equipped to insure the integrationist function or to assume responsibility for the holistic management of the patient's biophysical problems.

Given a family physician who is well trained, competent, concerned and aware of his limitations, it is difficult to compete with family practice in terms of cost, effectiveness, patient acceptance, convenience, economy and management of practice.

Family practice history

Nine years have elapsed since the American Board of Medical Specialties acknowledged family practice as the 20th recognized medical specialty. This was followed by the American Academy of General Practice officially changing its name to the American Academy of Family Physicians. This resurgence of family practice was partly stimulated by the aspirations of American society for a physician to reverse the ever-increasing fragmentation and depersonalization of medical care. Additional factors contributing to this renaissance were discerning health planners, concerned legislators, dedicated family physicians, and earnest medical students who felt that family practice represented an answer to certain inequities in our health care delivery system.

The American Academy of Family Physicians recently conducted a survey to provide more information as to how physicians and other specialties view family physicians and family practice. A total of 225 specialists in pediatrics, obstetrics and gynecology, surgery, psychiatry, and internal medicine were surveyed.

Seventy-eight percent responded that there were too few family physicians to serve the needs of society. Sixty-five percent considered family practice as a recognized medical specialty. Eighty-five percent, a large majority surveyed, agreed that family physicians are needed just as much in cities as in rural areas.

Doctor Dean

Seventy percent agreed that family physicians are adequately trained to provide necessary patient services. Concerning the relevance of continuing medical education, most of the physicians surveyed, 68 percent, believe that it is possible for family physicians to keep current in their knowledge.

What is Family Practice?

Family practice is comprehensive medical care with particular emphasis on the family unit, in which the physician continues responsibility for health care, and is not limited by patient's age, sex, or by a particular organ system or disease entity.

Family practice is a specialty in breadth, which builds upon a core of knowledge derived from other disciplines, drawing most heavily on internal medicine, pediatrics, obstetrics and gynecology, surgery and psychiatry. Family practice establishes a cohesive unit, combining behavioral science with the traditional biological and clinical sciences. The core of knowledge of the family physician prepares him, or her, for a unique role in patient management, problem solving, counseling and providing the majority of care. The family physician utilizes a multidisciplinary approach, referring the patient when necessary to the appropriate health resource or medical consultant, but still preserving the continuity of care, and assuming the responsibility for the total health care needs of the patient.

Present status of family practice

The specialty of family practice was officially recognized in February of 1969, by the American Board of Specialties and The Council on Medical Education of the American Medical Association.

The American Board of Family Practice is a free-standing organization, whose purpose is to conduct examinations to measure competence in a special field of medicine (family practice), and to grant certification on the basis of performance in that examination. Its membership consists solely of its officers, and board of directors. Physicians whom it certifies are called diplomats. More than 9,000 diplomats have been certified since 1970. In 1976, a medical milestone occurred when the original 1,400 charter diplomats of the American Board of Family Practice participated in the first mandatory recertification of an American medical specialty.

In 1970, there were 10 family practice residency programs enrolling 100 residents in the United States of America. That number has proliferated to 325 programs in 1977, training over 5,400 residents.

The residency program consists of three years of formal training following graduation from an accredited medical school, combining traditional in-patient hospital experience in internal medicine, obstetrics, gynecology, pediatrics, surgery and psychiatry, coupled with equal preparation in ambulatory care served in a family practice out-patient module.

In 1970, there were five departments of family practice in the medical schools of the United States. In 1978, that number has increased to 84 departments and 13 divisions. Thirteen other medical schools are developing curricula to expose medical students to the principles of family practice, in their undergraduate medical endeavors. Of the 131 medical schools in the United States of America, 84 percent have some activity in family practice.

The American Academy of Family Physicians has a membership of 39,000 members, making it the second largest medical organization in America and the largest specialty association. History was made in 1977, when the four highest offices in the American Medical Association were occupied by family physicians, all members of the AAFP. They are John H. Budd, MD, of Cleveland, president of the AMA; Robert B. Hunter, MD, of Sedro Wolley, Washington, chairman of the board of directors; William Y. Rial, MD, of Swarthmore, Pennsylvania, speaker of the house of delegates; and John Sammons, MD, of Baytown, Texas, executive vice-president.

The future of family practice

It is projected there will be a shortage of family physicians until the year 2000, when there will be one family physician per 2,000 residents in this country. The so-called "minimal acceptable" of one family physician for 2,500 U.S. residents will be achieved in 1988. This is comparable to the present situation in Western Europe and Canada. However, the overall figures at this time are one family physician per 3,300 residents, while the overall U.S. physician-patient ratio is 1 to 569.

In conclusion, the creation of family practice as a new medical specialty set the stage for the rejuvenation of the family physician. During the past nine years there has been a mushrooming in this distinctive approach to family health care. Family practice residency programs continue to blossom at an astounding rate. Medical students have eagerly accepted the new specialty, making it one of the most sought-after residencies. Medical academicians are adopting the principle of continuity of care and comprehensive care with emphasis on the importance of psychological factors in relation to health and disease.

These have been gratifying times for those who have struggled so devotedly and resolutely to advance the philosophy of family practice. We must continue to see that its basic principle and philosophy are not altered with the passage of time.

Doctor Dean is immediate past president of the Michigan Academy of Family Physicians. ◥

'Living will' bill acceptable to legislation committee

The Committee on State Legislation and Regulations, chaired by W. E. Maldonado, MD, of Lansing, has monitored the development of the proposed Medical Treatment Rejection Act over the past year and after careful study recommended to The Council that MSMS find the Act acceptable to physicians.

The Michigan proposal is different from any other "death and dying" legislation in that it provides for written informed consent by the patient rather than a directive to the physician. This consent by the patient is called a "Living Will."

Major provisions of the Medical Treatment Rejection Act are: (1) All competent adults have the right to accept or reject medical treatment (informed consent); (2) Right of informed consent can be transferred to a designated agent who has the authority to make medical decisions when the appointer is "incapable of making decisions"; (3) The attending physician makes the determination of when the appointer is incapable of making decisions (at this point the agent is called in and consulted); (4) Physicians and other health care personnel under the direction of a physician are excused from liability when administering, withholding or withdrawing medical treatment; (5) An individual may sign an advisory document which guides the agent and/or physician but which is not binding; (6) The document designating an agent can be revoked regardless of mental competency by writing a statement of revocation, by defacing or destroying the document or by making an oral statement; (7) This act does not condone, authorize, or approve mercy killing or suicide, and (8) Penalties are provided for violations of the act.

MSMS task force has two priorities for cost control

The special Task Force on Medical Care Costs, established by the 1977 House of Delegates, has submitted the following plan of work and priorities to The Council:

(a) The first priority is to develop a realistic program of physician cost containment initiatives at the local hospital level. The focus will be on coordination of admission and surgical scheduling, greater use of outpatient surgery, early and pre-admission testing, cost effective laboratory and X-ray services, early discharge, greater use of extended care facilities, nursing home and home care services, and development of primary care centers.

(b) As a second priority the Task Force will divide itself into four study groups to study the four major studies contained in the Report of the National Commission on the Cost of Medical Care. The Task Force Chairman, Frederick W. Van Duyne, MD, of Flint, plans regular meetings of the study group so a definitive program for medical care cost containment may be brought to fruition.

For additional information contact Richard Campau, MSMS, Box 950, East Lansing, MI 48823.

By Katie Brewbaker
MSMS staff

PS committee hears reports of TV shows

At a recent meeting of the Public Service Committee it was reported that four communities now feature local physicians on public service television programs.

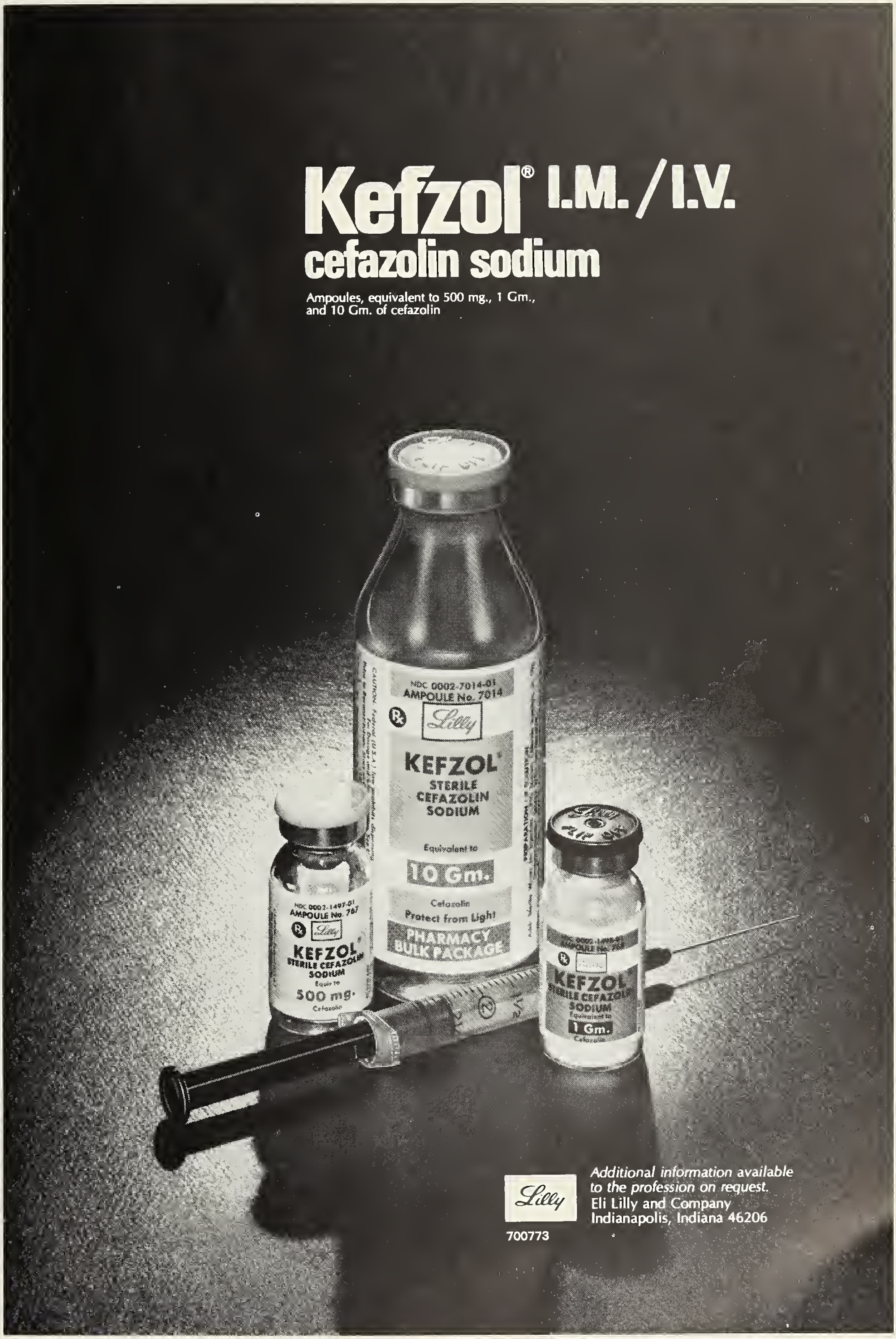
Channel 56 in Detroit airs "Housecall" monthly, a program which gives the viewing audience an opportunity to call in questions to a panel of physicians. Approximately 150 calls are received during each program.

Channel 23 in Lansing offers a similar live call-in program monthly. Grand Rapids Channel 13 features a video-taped medical program with a panel of physicians answering written questions received from viewers.

The medical program shown in the Bay City-Midland-Saginaw area on Channel 19 alternates between two formats. One month the program is devoted to call-in questions and the following month the topical approach is used. The idea of developing a "Housecall" program for the Traverse City area currently is being explored.

MSMS policy: marijuana penalties too stiff

The Council approved the following policy statement of the use of marijuana submitted by the Committee on State Legislation and Regulations: "The Michigan State Medical Society abhors the use of marijuana and its attendant deleterious effects on the human body. It finds, however, that criminal penalties are excessive and supports any legislation to correct that inequity."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Indianapolis, Indiana 46206

Michigan's AMA delegation

The Michigan delegation heard its resolution on death and dying debated at the recent interim AMA House meeting in Chicago. The delegation also was pleased to have the AMA pass a resolution against discrimination in insurance reimbursements to participating and non-participating physicians. From left, front row, are Donald N. Sweeny Jr., MD, Detroit; Thomas R. Berglund, MD, Portage; Brooker L. Masters, MD, Fremont; and James Danforth Jr., MD, Detroit. Second row are Donald K. Crandall, MD, Muskegon; Robert D. Burton, MD; Frank N. Walker, MD, Detroit, and Richard J. McMurray, MD, Flint.
(See related article, page 100.)

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures. necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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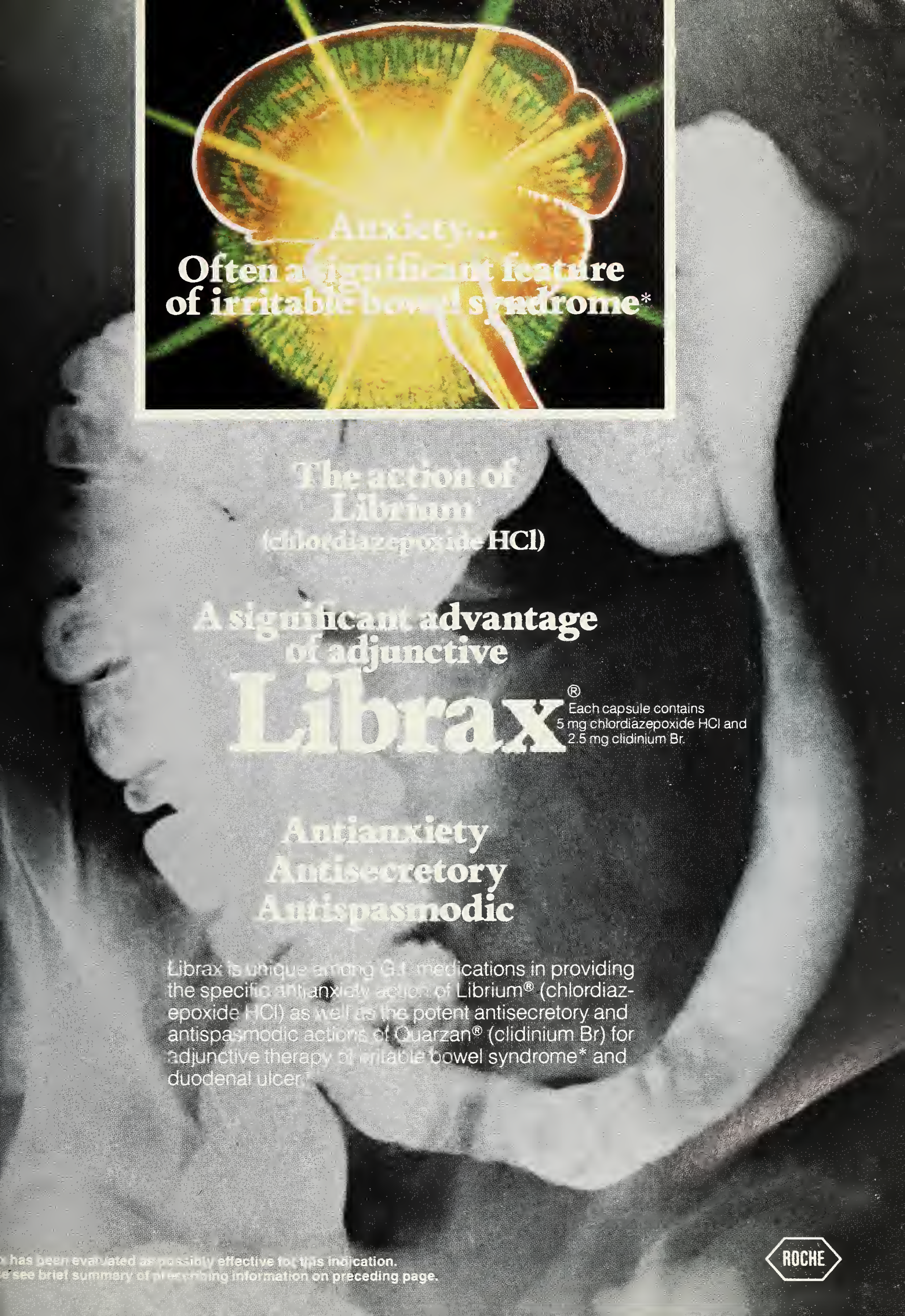
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x has been evaluated as possibly effective for this indication.
e see brief summary of prescribing information on preceding page.

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Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately i abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficienc or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

1954
1978
Time is the test of all things

ns of potassium ion may cause death through rdiac depression, arrhythmias or arrest. This ıg should be used with caution in the presence cardiac disease.

In hypokalemic states, especially in patients a salt-free diet, hypochloremic alkalosis is a ssibility that may require chloride as well as tassium supplementation. In these circumnces, Kaon (potassium gluconate) should be pplemented with chloride. Ammonium chloe is an excellent source of chloride ion (18.7 q. per Gram), but it should not be used in tients with hepatic cirrhosis where ammonium ts are contraindicated. Other sources for loride are sodium chloride and Diluted drochloric Acid, U.S.P.

It should also be kept in mind that ammonium cle cation exchange resin, sometimes used to at hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

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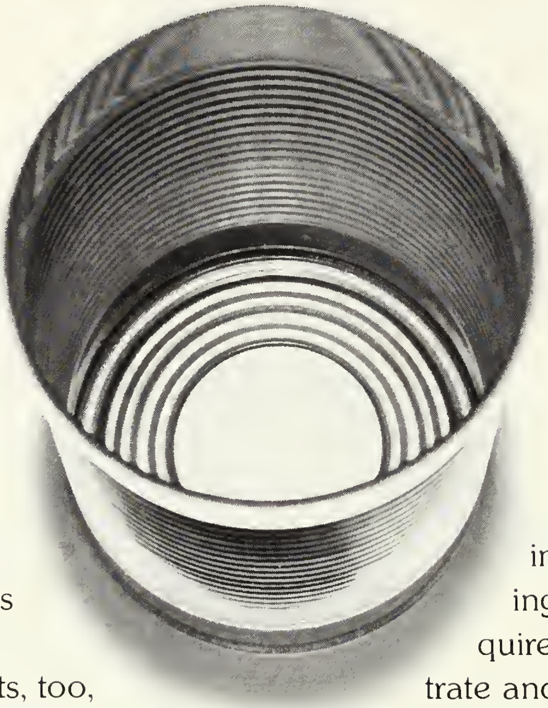

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News

By Katie Brewbaker, MSMS staff

Nine physicians on the staff of William Beaumont Hospital, Royal Oak, have a long association with Partners of the Americas and its program to share health services with the Dominican Republic and Belize. Active participants are **Gary J. Welsh, MD, Hector J. Inchaustequi, MD, John B. Bryan, MD, Alan E. Bolton, MD, James B. Blodgett, MD, James A. Catto, MD, Gerald F. Conway, MD, Joseph R. Meerschaert, MD,** and **Jose E. Yanez, MD.**

Philip E. Hill, MD, Petoskey, and **Rachel B. Keith, MD,** Detroit, have been appointed by University of Michigan President Robben W. Fleming to a nine-member statewide citizens group to advise the University on planning a new main patient unit at the U-M Hospital. The new advisory committee will assist the University from initial planning to final construction of the new facility. The project is expected to take six to eight years and estimated to cost approximately $140 million.

Five Detroit physicians recently visited China to get a first-hand look at Chinese hospitals and health care. Spending 18 days in China were **Alexander Walt, MD, Daniel Hollander, MD, Patricia Hollander, MD, Joseph Hess, MD,** and **Charles Vincent, MD.** An article on their observations appeared in the fall issue of *Pacemaker*, house publication of Harper-Grace Hospitals.

Erwin J. Haas, MD, Grand Rapids, has published a lead article on tuberculosis meningitis in the *Archives of Internal Medicine* magazine.

The September issue of the *New York State Journal of Medicine* featured an article by **Sarla Puri, MD,** Grand Rapids, entitled, "Scherosing Mediastinitis Presumed to be Due to Primary Aspergillosis."

Mary Ryan Miles, MD, from the Department of Human Development at Michigan State University, has co-authored an article published in the Oct. 24 issue of *JAMA* entitled, "Recurrent Vaginal Candidiasis: Importance of an Intestinal Reservoir."

The December 12, 1977 issue of *JAMA* featured an article on "Brain-Stem Compression in Rheumatoid Arthritis" co-authored by **Robert C. Davidson, MD, John R. Horn, MD, James H. Herndon, MD,** and **Oliver D. Grin, MD,** all of Grand Rapids.

Two Kalamazoo physicians received awards for research papers at the first Michigan Family Practice Research Day at Michigan State University. **Gary E. Ruoff, MD,** was awarded top honors for his paper on "A Five-Year Study of Colestipol HCL in Hypercholesterotemic Patients in Family Practice" and the award for the best paper by a family practice resident was given to **Kenneth S. Berneis, MD,** for his presentation on "Office Detection and Management of Hypertension: The Use of Home Blood Pressure Monitoring."

Physicians appointed to local health department posts are: **Dewain Silvernale, MD,** medical director, Berrien County Health Department; **Kenneth E. Rowe, MD,** health officer/medical director, Dickinson-Iron and Western Upper peninsula District health departments; and **James M. Davis, MD,** health officer/medical director, Lenawee, Cass, Branch-Hillsdale-St. Joseph, and Van Buren county health departments.

John P. Papp, MD, is the new president of the Michigan Society of Gastrointestinal Endoscopy.

A new method of treating cancer of the rectum has been developed by physicians at Harper-Grace Hospitals in Detroit. The technique involves the use of drugs and X-ray radiation treatments to patients for four to six weeks before surgery is performed. Taking part in the new procedure and study are **Thomas R. Buroker, MD, Norman D. Nigro, MD, Juan Correa, MD, Vainutis K. Vaitkevicius, MD, Michael Samson, MD,** and **Basil Considine, MD.**

Three physicians were recipients of Wayne State University Alumni Awards at winter commencement exercises. Recognized as outstanding WSU graduates were **Herbert A. Raskin, MD,** an international authority on substance abuse, **Peter A. Martin, MD,** well-known for his work in mental health and marital therapy, and **Jack Ryan, MD,** long active in the WSU Medical Alumni Association.

An important moment in the growth of the Michigan Physicians Mutual Liability Company came recently when the company was reinsured by American Medical Assurance Company. The backing of AMACO (national insurer of state medical society insurance companies) allows the MPMLC to offer greater coverage. Signing papers were, seated from left, Vernon V. Bass, MD, Saginaw, MPMLC president, and Ernest P. Griffin, Jr., MD, MPMLC secretary-treasurer. Standing from left are Norman F. McLellan, vice president, Marsh-McLennan, insurance consultants: William Cheeseman, East Lansing, MPMLC administrator, and William Gaugier, East Lansing, MPMLC comptroller.

Sketch by Kathy Minnerly.

Michigan snow skiing techniques all wrong for the caribous

By Robert J. Toteff, MD
Saginaw

(The following is excerpted from the author's account of his adventures while skiing in the Caribou range of the Canadian Rockies. Skiers must be helicoptered to the top of the slopes there.)

And now the time came for us to be taken to the mountain. Our group of 12 got into the helicopter with appropriate enthusiasm. I guess we all felt the thrill of anticipation of the first encounter with powder. I also felt some apprehension. I was not sure I knew exactly what to expect despite all my apparent preparation. The scenery was exciting but not fully appreciated at this point. Most members of the group were nervously joking, adjusting goggles, securing zippers on pockets and generally being busy.

We arrived at the landing site and I marveled that the pilot could place that 'copter on an area no bigger than a postage stamp. Seat belts were unbuckled, doors were opened and we were out in knee-deep snow. We all went into our proper stance as taught, huddled together, faces covered and all clothing closed against the swirling snow being sucked up by the rotor blades. Soon the helicopter moved gracefully away and there was silence, with only the wind on the crown of the area.

Quickly and efficiently we moved off the landing area and set about putting on our skis. This was done with a minimum of talking as everyone prepared to moved down the mountain. Time was essential and there was no leisure yet for sight-seeing or enjoying the splended view.

I was able to look about enough to realize I couldn't see over the edge of the landing site either to the back or front. Suddenly I knew how totally dependent we were on the guide.

He asked, "Ready?" I knew the nod of my head meant physically I was ready. But mentally I had my reservations. He said we will move 50 yards down the hill to be away from the returning helicopter. We now could hear it approaching, and it was the only sound up there besides the wind. I knew it was cold because my face was numb but why was I sweating under my borrowed ski hat? Why were my fog-proof goggles suddenly fogged? The only other sound I heard was my heart pounding as I saw the guide disappear over the edge of the hill with each of our group beginning to follow him.

Suddenly breathless

The snow was wind-swept and hard and swished under the skis as we went over the edge. Suddenly, I was breathless at the beautiful panorama that unfolded down the snow field! There the snow suddenly got lighter and turning appeared to be easier, as I watched the experienced skiers of my group make apparently effortless turns. Seeing the new tracks in the otherwise untracked snow was a thrill. However, it seemed harder than I thought it should and I felt uneasy and strange.

I tried to remember what the difference in technique should be, but found myself instinctively doing what I do back on Michigan snow. It was all wrong. I weighted the downhill ski and suddenly the uphill ski began to separate and track uphill. I was able to forcefully slide to a stop. I re-positioned myself and started again, thinking strongly about trying to forget hardpack midwestern technique which, I realized, is instinctive to me. Now I began to feel like a novice for I found myself trying to talk myself into each maneuver — "lean forward, don't sit back, don't let your arms get behind you," and on and on.

I began not only to feel like a novice, but to ski like one. I was not completing my turns, not properly checking myself so that I began to pick up more speed than I wanted and could control. I attempted a hard turn into the hill to check myself

(Continued on page 96)

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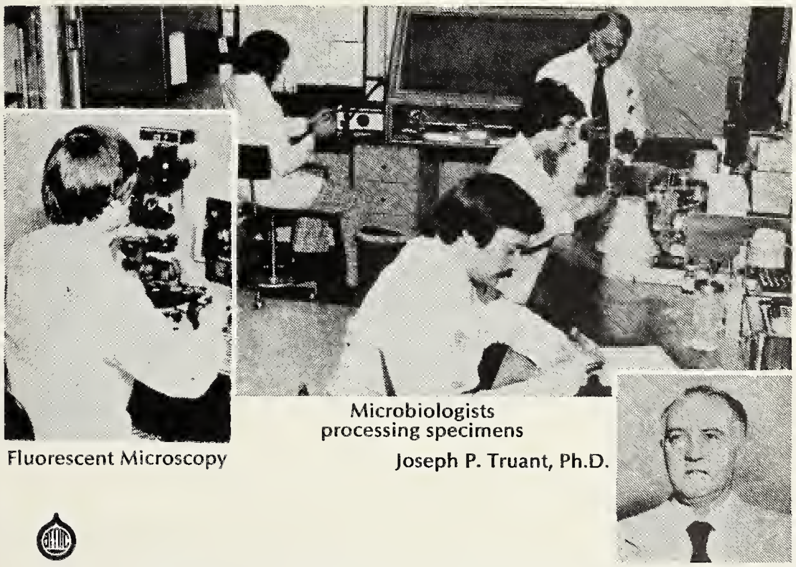

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and, at that moment, I did all the wrong things, straightening up, sitting back, dragging a pole and, you guessed it — my first fall in powder!

Now, I have heard stories of powder falls and the difficulty of getting up, but I was not prepared for what was to follow. Both skis released, hat and goggles were off and the flying powder found every opening in my clothing. I thought to myself, the only good thing was that it was a soft landing.

I collected my wits and clothing and set about trying to get up. Since both skis were off I thought it would be easy enough merely to stand up. I tried to use a pole for support but it dug into the snow all the way to the handle. Next I tried to support myself on my arm only to have that sink also. It became obvious that any small part of my body or equipment would not be support enough to get up on. I ended by bracing my feet against one loosened ski, and using the length of the other ski to support my arm. In this manner I got to a standing position — deeper than knee deep in the snow! Then came the cleaning of the goggles, removing the snow from my hair and hat and getting into my skis. I was amazed how winded I had become in trying to extricate myself from the prone position! However, I felt quite accomplished at having been able to figure out a way to get up.

Some of the others in my group were having similar experiences and when we regrouped we began to analyze our mistakes and experiences. It became obvious that each fall would take a great toll on our strength. Little did I realize how expert I was to become in getting up from that prone position. Having experienced that fall and the effort expended to get up, I began to tighten up in anticipation of the same experience. Therefore I was not able to ski relaxed and, consequently, all sense of rhythm and balance seemed to leave me. Every muscle seemed to be set in spasm, unable to respond to any request. Even the muscles behind my ears were tired from trying to hold my too-large borrowed hat on! The pitch of the hill was quite steep, but no steeper than I was used to otherwise. With each fall I experienced more fatigue which further complicated my concentration. Likewise, it took time to get up and as the others in the group waited for the fallen skiers to join them, they had rested and were ready to take off on the next section of the run. But it was necessary for the recently arrived skiers to start their next run without benefit of the several minutes' rest. Now, this would have been okay except for the fact that I usually was a fallen skier!

Fell 20 times

It has been estimated that the energy expended getting up from one fall is equivalent to the energy expended in one complete run. Now I have to tell you, I must have fallen 20 times that first run! So, figure for yourself the level of my fatigue!

But there was more to come. I was surprised and horrified when our guide said the last half of our run would be through the trees. "Last half?? Through the trees??"

This was my first recollection of actually beginning to talk to myself on that mountain. It was also something that I was to become expert at! I talked a lot to myself out there. I know I talked to God. Sometimes I asked questions such as "God, what am I doing up here?" I think I asked that one so many times that one time I distinctly heard the answer "Dummy!" I know I talked to his Son up there.

We had been on a long traverse across a snow field when we were told to follow each other with 30 yards between us. When we got to the side we stopped. The next instructions were to follow one by one over the next knoll and as soon as the man's head in front of us disappeared over the hill, we were to start. My turn came and as I went over the hill, I distinctly remember exclaiming breathlessly "Jesus Christ! Straight down?" You must know, this is not my customary vocabulary, but strange things happened to me up on that mountain.

So, now we still had to go "through the trees." I have never been so intimidated by anything in all my life! I was afraid, anxious and generally felt inept. Hey, but this was supposed to be fun! I'd waited for two years to be able to enjoy this.

The snow in the trees was not the best. It was "breakable crust" and more difficult to ski. We were nearing the pick-up point. I was having trouble with my skis diving beneath the crust. They were somewhat stiff and the bindings were set too loose.

However, making a turn I caught my outside edge and fell head first down the hill. One ski released but was buried. My safety strap on the buried ski was drawn tightly by my weight going downhill. Even though I could reach the safety strap I could not release it. I was lying on my back and the one free foot with ski attached was maneuverable.

Not a bad place to go

Despite all my attempts I seemed unable to extricate myself. I figured I could pull myself up the slope enough to loosen the safety strap and release myself. Seemed simple enough. I succeeded in inching uphill, sat up to release the strap only to realize the warmth of my body softened the snow so I proceeded to slide back down, losing the gain I had made.

I began to tire now and I recall lying back discouraged, looking up at the sky and saying "Well, this really isn't a bad place to go." I must have frightened myself with such a thought and succeeded in getting out a good burst of adrenalin, for suddenly my free leg began to windmill like crazy and my momentum popped the buried ski free!

Doctor Toteff is an MSMS councilor and is past president of The Michigan Academy of Family Practice.

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- Male Climacteric
- Eunuchoidism, Eunuchism
- Post-Puberal Cryptorchidism

New Double-Blind Study ANDROID-25 vs. Placebo*

*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy**, Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Testifying in court soon? Keep these tips in mind

James Allan Davis, Jr., MD, of Omaha, recently offered the following 20 suggestions to help physicians when testifying in court. The ideas appeared in the June 1977 issue of the state journal of the Nebraska Medical Society.

Permission to carry this list has been granted to *Michigan Medicine* by the Nebraska Medical Journal and by Doctor Davis, who is assistant professor of psychiatry; Fellow, Group for Advancement of Psychiatry, Nebraska Psychiatric Institute. Doctor Davis says he developed the suggestions, "based upon personal experience and a close relationship with a trial attorney."

"Hopefully these ideas will help some doctors give better testimony and feel less anxiety on their day in court," Doctor Davis adds.

Here are Doctor Davis' suggestions:

1. Call the attorney when you get your subpoena to appear in court and ask him what he wants.
2. Keep good records.
3. A subpoena only means you must go to court, it has no reference to guilt or innocence.
4. Be prepared and stick to the facts.
5. Dress conservatively and be well groomed.
6. Find out all you can about the judge before going to court.
7. Ask yourself the question, "Do psychiatrists belong in court?" Answer it to your satisfaction.
8. Visit court to desensitize yourself.
9. Speak in layman's language as much as possible.
10. Think *before* you speak and only answer the questions asked.
11. Never show anger. Many attorneys' ploys will make you angry, but if you show it you will lose face with the judge and jury.
12. Talk directly to the jury and watch their non-verbal behavior. The testimony is for *them*.
13. If you go to court as an expert witness, don't examine the defendant first unless the court asks you specifically to do this. If you follow this rule you can answer hypothetical questions easier.
14. Be careful of language that is only understood by other specialists, e.g. psychopathology, lying, ambivalence, etc. You will probably have to define them.
15. Don't frighten the layman with your omnipotence. Obsessive thinking doesn't belong in court.
16. Don't bluff. If you do not know the answer, say so.
17. Answer questions one at a time. (Attorneys like to couple questions before you can answer. Usually the answer to the first is no, and the second is yes.)
18. Discuss your fee in advance with your attorney. The other will likely attack it. Most charge $35-50 per hour. Remember you get paid both for the time of preparation and the testimony.
19. Keep your cool.
20. Good Luck.

The following medico-legal cases are detailed in recent issues of the AMA's newsletter, *Citation*. They are listed here for MSMS members' notification.

Experts' Testimony Barred by Similar Locality Rule, April 15, 1977, Michigan Court of Appeals, from the *Citation*, Vol. 35, No. 12.

City Hospital Immune from Liability for Negligent Diagnosis and Treatment, March 30, 1977, Michigan Court of Appeals, from the *Citation*, Vol. 35, No. 12.

Patient Denied Damages in Suit for Serum Hepatitis, March 29, 1977, Michigan Court of Appeals, from the *Citation*, Vol. 35, No. 12.

Missed Checkup A Defense in Medical Malpractice Suit, May 2, 1977, Michigan Court of Appeals, from the *Citation*, Vol. 36, No. 1.

Surgeon May Not Testify to Standard of Care for Reading X-rays, June 2, 1977, Michigan Supreme Court, from the *Citation*, Vol. 36, No. 1.

Court Remands Excessive Awards in Dental Malpractice Case, May 17, 1977, Michigan Court of Appeals, from the *Citation*, Vol. 36, No. 2.

Contributors to Hospital May Not Challenge Sale, March 29, 1977, Michigan Court of Appeals, from the *Citation*, Vol. 36, No. 2.

Liability

Prescribe with caution and lessen risk

(This article is the second in a series on risk management being presented in Michigan Medicine by the new MSMS Committee on Professional Liability. The committee is chaired by MSMS Past President Robert M. Leitch, MD, Battle Creek. These articles are taken from a series of cassette tapes prepared by the Illinois State Medical Society.)

Prescribing medication is a routine procedure, but physicians who are lax in their prescribing habits may pay a severe penalty — specifically, a malpractice suit. Here are five basic precautions which will go a long way toward reducing your chances of being sued:

(1) If your handwriting is especially hard to read, print the prescription. Physicians' illegible handwriting has been the butt of countless jokes, but it can cause serious errors.

(2) Write complete orders for hospitalized patients. Specify mode, dosage and route of administration. Don't force a nurse to make these decisions.

(3) Inform the patient of possible side effects and any inherent dangers. Tell him what to do if he experiences a reaction, and urge him to contact you immediately if there are serious complications. Familiarize yourself with the contraindications of any drug you prescribe, and keep abreast of treatments for toxic reactions.

(4) Explain the dangers of continuing medication beyond the prescribed period or discontinuing it prematurely. When prescribing a drug which can dull the senses, instruct the patient not to drive an automobile or participate in hazardous activity.

(5) Exercise extreme caution when prescribing drugs classified as investigational by the FDA. These drugs must be used exactly as the FDA specifies, and you must obtain the patient's written permission. The consent form should be carefully worded to insure that he has given his informed consent.

Finally, if relatives are caring for a patient, make sure they are aware of the possible side effects and your precautionary instructions.

Modane®
(danthron)
LAXATIVE TABLETS

one tablet usually brings
gentle, overnight relief

WARREN-TEED
LABORATORIES, INC.
DIVISION OF ADRIA LABORATORIES INC.
COLUMBUS, OHIO 43215

Question: Must physician or insurance company report examination results to patient?

(The following is another in the series of recent opinions on medical-legal problems of general interest, provided by MSMS legal counsel for MSMS members. It has been adapted somewhat from the original opinion.)

Recently, an Upper Peninsula physician asked MSMS legal counsel the following questions:

1. Does a physician examining a patient for an insurance company have an obligation to report his interpretation of the findings to the patient or does this obligation exist only with the insurance company.

2. What are the ethics involved in a case when an examining physician for an insurance company recommends treatment, and further surgery to the patient, without the knowledge or consent of the attending physician.

Legal counsel replied:

The second question, on ethics is something that perhaps I should leave to the ethics committee of your county society or to the MSMS Judicial Commission. My knowledge is limited to the Judicial Council opinions of the AMA, which I here quote:

> "7. RELATIONSHIP WITH ANOTHER PHYSICIAN'S PATIENT: A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow;
>
> "9. SERVICES TO PATIENT OF ANOTHER PHYSICIAN: A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed."

If these opinions do not precisely fit your facts, feel free to make the contacts above suggested.

In partial answer to the first question, there is still no Michigan law extant on the subject. I am told that a case involving Johns-Manville Co., resembling your facts, was recently decided at a lower court level in California. That case would not be a precedent in Michigan but the case is interesting in that the California court evidently said the physician must inform the worker of his illness even though the insurance company or the employer company is paying for the services.

This information is advisory only and is *not* intended to imply or establish a standard of care, or to substitute for advice of personal legal counsel.

AMA opposes discrimination in par and non-par

New AMA policy officially opposes third-party differentiation in payments to participating and non-participating physicians. This policy was established through work of the Michigan delegation to the AMA at the recent interim AMA House of Delegates meeting in Chicago.

The Michigan delegation introduced a resolution opposing discrimination between par and non-par physicians, only to see a reference committee propose the resolution be referred to the AMA Board of Trustees for further discussion.

"This would have delayed for at least six months, until the next AMA house meeting, any possible adoption of the resolution," says Robert E. Rice, MD, Greenville, Michigan delegation chairman.

"We felt this issue was important enough that the policy should be established now," he says. "Without too much effort, we enlisted the support of several other states' delegations who supported Michigan's wish for action at this meeting.

"The policy was overwhelmingly supported by the entire body of delegates without any really substantial negative votes."

An amended Resolution 64 was passed as follows:

RESOLVED, that the American Medical Association oppose third-party differentiation between covered services provided by participating and non-participating physicians as discriminatory against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physicians; and be it further RESOLVED: That this position be communicated to all health insurance carriers.

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl

for the pain for the pathogens

☐ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

*Nonobstructed; due to susceptible organisms

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

☐ **Appropriate antibacterial therapy:** up to three days therapy with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole), 0.5 Gm tablets.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

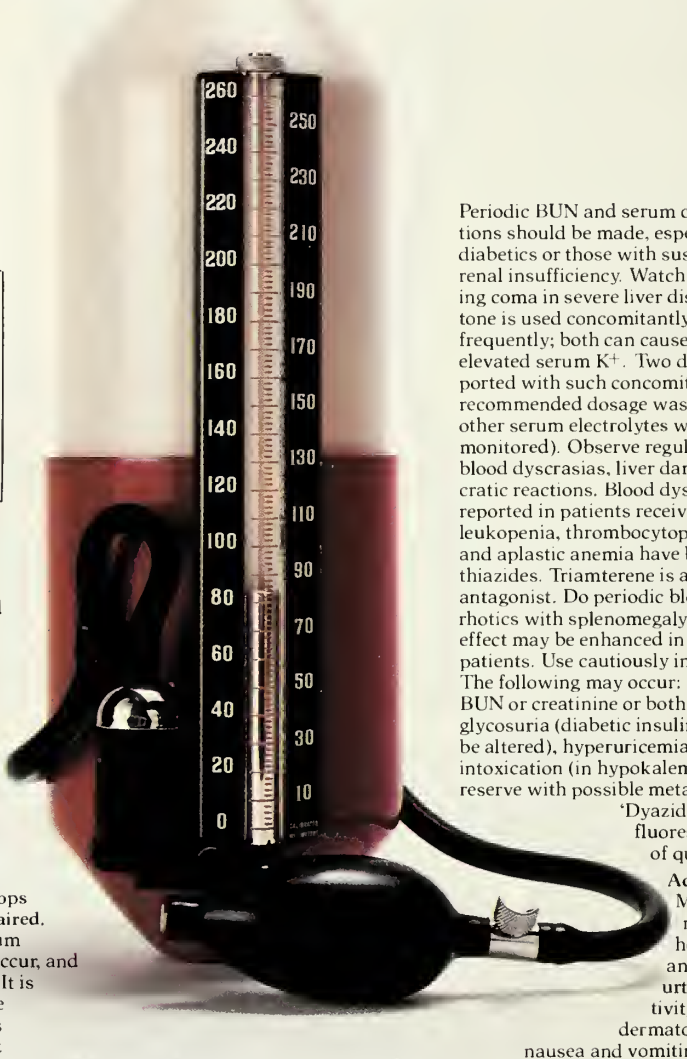
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

> * Warning
> This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

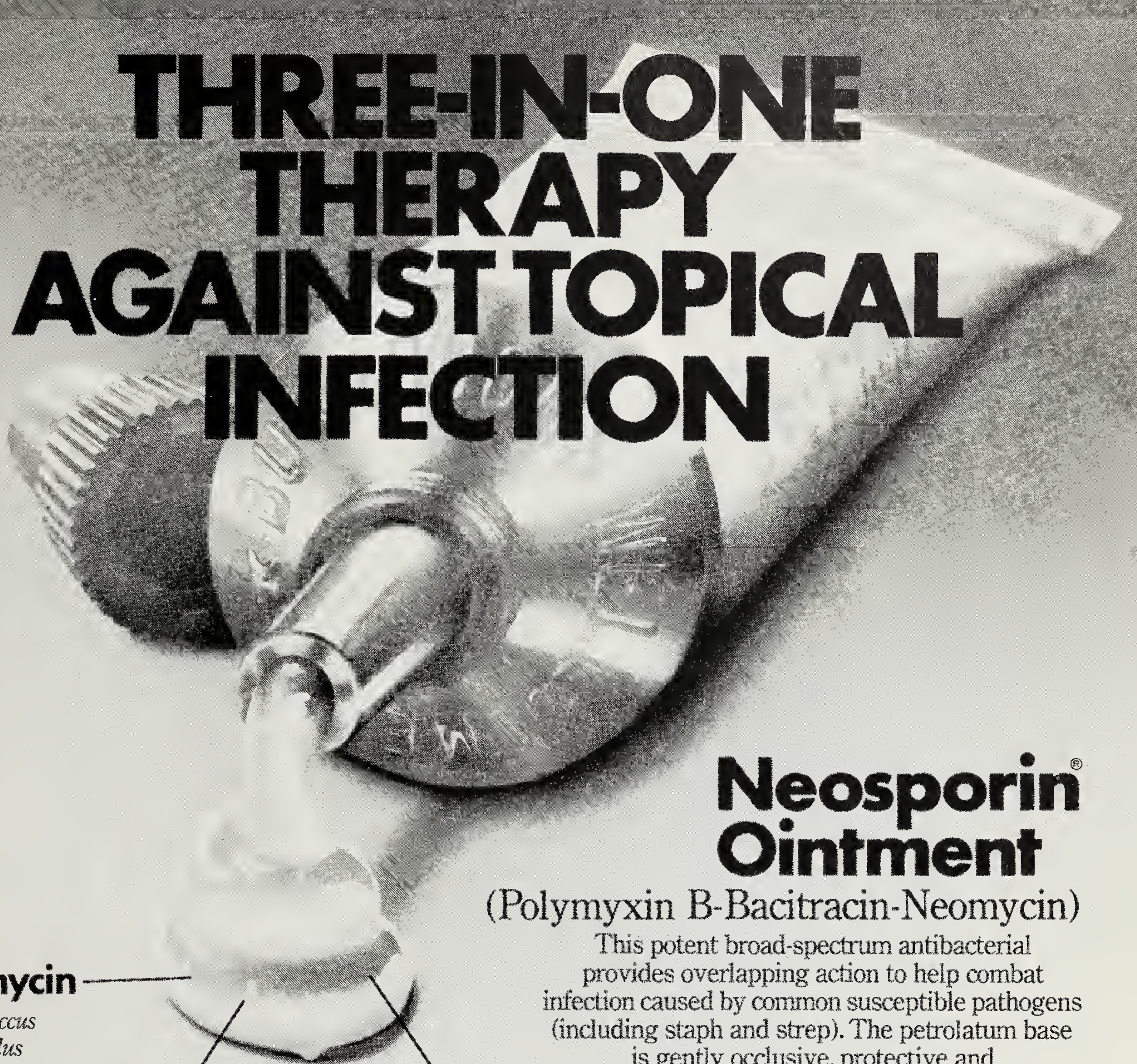
Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.*
SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company



THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin
Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin
Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B
Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

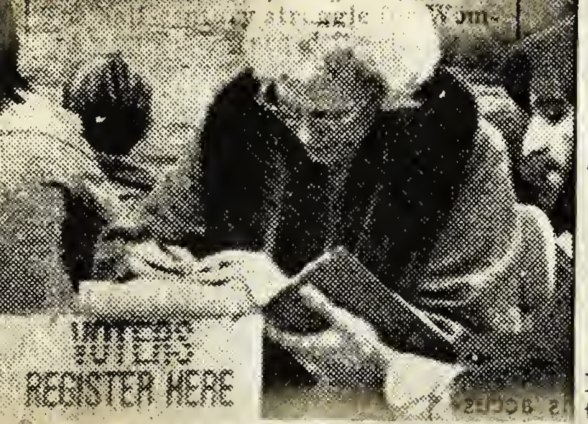
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification
at His Home Without
Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony,
But Both Factions Are

WASHINGTON, Aug. 26, 1920—[illegible] struggle for Wom-



NEW YORK THURSDAY, AUGUST 15,

Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,0
Persons When States Adopt Cooperating Laws—He
the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14 The Social Security Bill, pr a broad program of unemp insurance and old age p and counted upon to bene 20,000,000 persons, became day when it was signed b dent Roosevelt in the pre those chiefly responsible ting it through Congress.

Mr. Roosevelt cal [illegible] "the cornerstone [illegible] which is being [illegible] me s comple [illegible]

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

---

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

SAN FRANCISCO, June 26, 1945

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the eight United States delegates to

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co

SIGN

the Dra Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that he foresees no need for

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

Business

Things MDs should know about new tax laws

There have been many changes in the tax law affecting the filing of tax returns for 1977. Here are some questions, with answers, from the Internal Revenue Service about some of these changes:

Q: *I understand that if I move in 1977 I won't have to move as far to be able to claim my moving expenses. Is that true?*

A: Yes. The old distance requirement of 50 miles has been reduced to 35 miles.

Q: *Haven't some of the maximum allowance limits been changed too?*

A: Yes. You may claim up to $3,000 for expenses involved in buying, selling, or renting a principal residence, of which no more than $1,500 may be used for pre-move househunting and temporary living expenses. The old limits were $2,500 and $1,000 respectively.

Q: *I sold my house in 1977 and I'm over 65. Don't I get a special tax break because of my age?*

A: Yes. If the home you sold had an adjusted sale price of $35,000 or less, you pay no tax on any profit you made. Previously, the limitation was an adjusted sales price of $20,000 or less. You can take advantage of this tax break only once in a lifetime, and this benefit applies only to the sale of a home which has been your principal residence for at least five years of the last eight years.

Q: *What if my house has an adjusted sales price of more than $35,000?*

A: Then your tax break is prorated and you are taxed on only a portion of your gain.

Q: *I pay alimony to my former spouse, but I don't have enough deductions to itemize. Can I still claim the alimony on my return?*

A: Yes. Beginning in 1977, alimony will be an adjustment to income, similar to moving expenses. This means that you need not itemize deductions to claim alimony payments.

Q: *I usually itemize my deductions, but without my alimony payments I won't have enough to itemize. Won't my taxes be higher?*

A: Probably not. For example, suppose you are single, make $30,000 a year, pay alimony of $5,000, and have other deductions of $1,000. In the past, you could deduct the $6,000 in itemized deductions, plus your exemption, to find your taxable income. Now, without itemizing, you can deduct your $5,000 in alimony payments and your exemption. Since the zero bracket amount is $2,200 ($3,200 for marrieds filing jointly), you will end up, in effect, with a lower taxable income, and a lower tax.

Q: *I make child support payments. How much do I now have to pay in order to claim the exemptions for my children?*

A: Under the old law, you had to pay $1,200 or more for the support of one or more children. You now have to pay $1,200 toward the support of *each* child. This applies only if your divorce decree or agreement does not specify who is to get the exemptions, and you are the noncustodial parent.

Q: *There was a lot of talk about changing the sick pay exclusion. What's the final rule for 1977?*

A: Sick pay for temporary absences from work is no longer excludable from taxable income. You must be totally and permanently disabled in order to exclude all or part of your disability income.

— Department of the Treasury
Internal Revenue Service

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY???

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc.

The Professional Overhead Expense plan sponsored by the MSMS has again been improved. In addition to the lower premiums, CHECK THESE FEATURES:

☑ Up to $3,000 monthly benefit
☑ Waiver of Premium
☑ Survivors' Benefits
☑ Professional liability premiums are a covered expense
☑ Premiums deductible as a business expense
☑ Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more

Call Toll Free: 800/292-2136
For Information and Applications
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Professional Group Insurance Administrators
serving
the Michigan State Medical Society Exclusively

Underwritten by
Provident Life and Accident Insurance Company

Category I courses

Date: Feb. 18, **Human Sexuality: Myths and Misunderstandings. Location:** Sheraton Southfield Hotel. **Sponsor:** Northland Clinic P.C. **Co-Sponsor:** Detroit Psychiatric Institute, WSU School of Medicine. **Cost:** $45. **Contact:** Mrs. Francine Wade, Northland Clinic, 313/559-8190. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 20-24, **Emergency Medicine. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** American College of Emergency Physicians. **Cost:** $225 for physicians, $125 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 36¼ hours of Category I Credit.

Date: Feb. 21-23, **Art of Negotiations Seminar. Location:** Long's Convention Center, Lansing. **Sponsor:** AMA and MSMS. **Cost:** $85. **Contact:** William E. Madigan, MSMS headquarters. **Approved for:** 12 hours of Category I Credit.

Date: Feb. 28, **Continuing Pathology Conference. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 6½ hours of Category I Credit.

Date: March 1, **Cooperative Chemotherapy Review. Location:** School of Medicine. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Contact:** Wayne State University Division of CME, WSU School of Medicine, 1206 Scott Hall, 540 E. Canfield, Detroit 48201, 313/577-1180. **Approved for:** 3 hours of Category I Credit.

Date: March 1, **Ambulatory Care. Location:** St. Joseph Hospital, Flint. **Sponsor:** St. Joseph Hospital. **For:** Family Physicians. **Cost:** $25. **Contact:** L. E. Simoni, MD, 313/238-2601, Ext. 435. **Approved for:** 8 hours of Category I Credit.

Date: March 8-10, **Hematology Review. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor, **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21 hours of Category I Credit.

Date: March 8-9, **Conference on Maternal and Perinatal Health. Location:** Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **Co-sponsor:** Michigan Section, Nurses Association, ACOG. **For:** Ob/Gyn, pediatricians, family physicians, nurses. **Contact:** Herb Auer, MSMS headquarters, 517/337-1351. **Approved for:** 14 hours of Category I Credit.

Date: March 16-17, **Newer Concepts in Gastrointestinal Surgery. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor, **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $130. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Because of space limitations, it is not possible to list the many continuing courses and series sponsored by many hospitals and organizations in Michigan. Information about those possible programs may be obtained from the accredited sponsors.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo State Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City State Hospital Traverse City
V.A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: March 22-23, Advances in Pediatrics. Location: Towsley Center for Continuing Medical Education. University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $120. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 28-30, Art of Negotiations Seminar. Location: Hospitality Inn, Lansing. **Sponsor:** AMA and MSMS. **Cost:** $85. **Contact:** William E. Madigar, MSMS headuarters. **Approved for:** 12 hours of Category I Credit.

Date: March 29, Breast Cancer — 1978. Location: Hilton Inn, Lansing. **Sponsor:** E. W. Sparrow Hospital, Department of Family Practice, and Capital Chapter of MAFP. **Contact:** R. W. Pomeroy, MD, Director, Continuing Medical Education, E. W. Sparrow Hospital, Box 30480, 1215 E. Michigan Ave., Lansing, 48909. **Approved for:** 7 hours of Category I Credit.

Date: March 30-31, The Spine and Spinal Cord. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 31-April 1, Regional Drug Abuse Conference. Location: Water Tower Hyatt Hotel, Chicago. **Sponsor:** AMA. **For:** Physicians in Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin. **Cost:** $50 members, $100 nonmembers. **Contact:** E. M. Steindler, director, Department of Mental Health, Division of Scientific Activities, American Medical Association, 535 N. Dearborn, Chicago, 60610. **Approved for:** Hour for hour Category I Credit.

Date: March 31-April 1, Advanced Cardiac Life Support Certification Course. Location: The Kellogg Center for Continuing Education, Michigan State University, East Lansing. **Sponsor:** Michigan Heart Association. **Co-sponsor:** Michigan State University College of Osteopathic Medicine and Ingham Medical Center. **For:** All specialties. **Cost:** $160 physicians; $100 EMTs. **Contact:** Ann Tsiminakis, Conference Coordinator, Continuing Education MSU, Kellogg Center, 517/353-7822. **Approved for:** 16 hours of Category I Credit.

Date: April 1, Aging: Intergenerational family therapy promoting the process of growth for the elderly. Location: Ramada Inn, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** 313/545-1144 or 313/662-2330. **Approved for:** 3 hours of Category I Credit.

Date: April 3-7, Occupational Skin Diseases. Location: Detroit. **Sponsor:** Wayne State University School of Medicine Div. of Continuing Medical Education. **For:** All specialties. **Cost:** $250. **Contact:** Wayne State University Division of CME*** **Approved for:** 27 hours of Category I Credit.

Date: April 6-7, Seminar to Improve CME Instruction. Location: MSMS headquarters. **Sponsor:** MSMS CME Programming Committee. **Contact:** Herbert A. Auer, MSMS headquarters. **Approved for:** 9 hours of Category I Credit.

Date: April 6-7, Ophthalmology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education.* **Cost:** $140. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: April 12-13, Symposium on Child Development. Location: Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association. **Co-sponsor:** SMAHEC. **For:** Pediatricians, family practitioners, obstetricians. **Contact:** Valerie Lincoln, RN, Perinatal Coordinator, Bronson Hospital, 252 E. Lovell, Kalamazoo, 49007. **Approved for:** 11 hours of Category I Credit.

Date: April 13, Medical Aspects of Organized Athletics. Location: Hilton Inn, Lansing. **Sponsor:** Michigan State Medical Society. **For:** Team doctors, coaches, athletic trainers. **Contact:** Herb Auer, MSMS headquarters, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 14-15, The Wayne State University School of Medicine 11th Annual Cancer Symposium, "Cancer of the Colon and Rectum." Location: Gordon H. Scott Hall, 540 E. Canfield, Wayne State University, School of Medicine, Detroit 48201. **Sponsor:** Wayne State University. **Co-sponsor:** American Cancer Society, Michigan Division. **For:** Primary care physicians. **Cost:** $50. **Contact:** Melvin L. Reed, MD, FACP, Associate Professor, Department of Oncology, 4160 John R., Detroit 48201. **Approved for:** 8.5 hours of Category I Credit.

Date: April 17-21, Family Practice Review II. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-sponsor:** Michigan Academy of Family Physicians. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 37 hours of Category I Credit.

Date: April 25, Continuing Pathology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 6½ hours of Category I Credit.

Date: April 25, Infectious Diseases Symposium. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Hospital. **Contact:** Butterworth Hospital, Medical Education Office, 616/774-1835. **Approved for:** 8 hours of Category I Credit.

Date: April 27-29, Critical Care Symposium. Location: Wayne County Medical Society Headquarters. **Sponsor:** Wayne State University School of Medicine Div. of Continuing Medical Education. **For:** All specialties. **Contact:** Wayne State University Division of Continuing Medical Education.** **Approved for:** Undetermined hours of Category I Credit.

Date: May 4-5, The High-Risk Infant. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $75. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 12 hours of Category I Credit.

Date: May 6, Alcoholism: Special problems and techniques in working with families in which alcohol is a problem. Location: Ramada Inn, Lansing. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** 313/545-1144 or 313/662-2330. **Approved for:** 3 hours of Category I Credit.

Date: May 9-10, InterQual's Concurrent Review Seminar. Location: Hilton Inn Lansing/7501 West Saginaw Highway/Lansing, 48917 (517)627-3211. **Sponsor:** Endorsed by: Michigan Region VI PSRO, East Lansing; Western Michigan PSRO, Inc., Grand Rapids; Area VII PSRO, Ann Arbor. **For:** Medical Staff Members, UR Physicians, Administrators, Review Coordinators, Social Workers, All other hospital personnel. **Cost:** $130. **Contact:** Monica Eckart, Seminar Registrar, InterQual, 740 N. Rush St., Chicago, 60611. (Telephone registrations accepted, toll-free (800)621-6109; IL (312)751-2327.) **Approved for:** 8 hours of AMA Category I Credit and 10 hours American Medical Records Association.

Date: May 10, 18th Annual Spring Clinical Conference, "Practical Management of Cerebral Vascular Disease." Location: Kalamazoo Center, 100 West Michigan, Kalamazoo, Michigan 49006. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians. Internists, Neurosurgeons, General Practice, Emergency Medicine, Neurologists. **Cost:** $40. **Contact:** Charles L. Zeller, Jr., M.D., % SMAHEC, 252 East Lovell, Kalamazoo, Michigan 49006. **Approved for:** 7 hours of Category I Credit.

Date: May 10, Cancer Update. Location: Gordon Scott Hall, WSU. **Sponsor:** WSU Department of Oncology. **Cost:** $25. **Contact:** Ms. Jeanette Radman, Department of Oncology, WSU School of Medicine, Scott Hall of Basic Medical Sciences, 540 E. Canfield Ave., Detroit, 48201. **Approved for:** 6 hours of Category I Credit.

Date: May 10-12, Pediatric Clinic Days. Location: Children's Hospital, Detroit. **Sponsor:** Wayne State University School of Medicine Div. of Continuing Medical Education. **For:** Pediatricians. **Contact:** Wayne State University Division of CME** **Approved for:** Undetermined hours of Category I Credit.

Date: May 22-26, Internal Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 33½ hours of Category I Credit.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't of PBM/HPE, Ann Arbor, 48109.

**WSU Division of CME, Room 1206, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1180.

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

How new CME laws have affected Michigan MD stats

In 1976, a new requirement went into effect for Michigan medical doctors, according to which each physician must participate in continuing medical education in order to qualify for license renewal. There was some concern that this requirement might cause a loss in the number of physicians licensed, but, according to studies carried out by the Department of Licensing and Regulation, the supply of practicing physicians did not appear to be affected.

The table below, based on MCHIS data, shows the pattern of change. Although there was a slight decrease in the total number of physicians licensed by the state, the number who are in the state actually increased. The out-of-state licensees may include physicians who are licensed by, and practicing in, another state (many physicians retain a license in more than one state;) and retired physicians who formerly practiced in Michigan but who now live elsewhere.

Number of Medical Doctors Licensed by Michigan

	Year of Licensure		
Location	**1975**	**1976**	**1977**
Total Number Licensed	**15,211**	**15,668**	**15,558**
MICHIGAN	**11,098**	**11,237**	**11,703**
Out of State	**4,113**	**4,431**	**3,855**

The data are based on licensure records obtained at the time of completion of the annual January 1 renewal.

— MSMS Bureau of Economics

CATEGORY I */continued*

Date: June 3, Cultural Differences: The implication for treatment of cultural and ethnic differences among families and between family and therapist. Location: Ramada Inn, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** 313/545-1144 or 313/662-2330. **Approved for:** 3 hours of Category I Credit.

Date: June 8-10, Keyport-Gaylord Trauma Symposium. Location: Gaylord. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $25. **Contact:** Wayne State University, Division of CME.** **Approved for:** 12 hours of Category I Credit.

Date: June 25-30, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $200. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21½ hours of Category I Credit.

Date: Sept. 13, Third Annual Renal Disease Conference. Location: Kalamazoo Center, 100 West Michigan, Kalamazoo, Michigan 49006. **Sponsor:** Michigan Nephrology Center. **Cosponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians, Internists, General Practice, Nephrologists. **Cost:** $40. **Contact:** Jeffrey Block, M.D., Michigan Nephrology Center, 1521 Gull Road, Kalamazoo, Michigan 49001. **Approved for:** 7 hours of Category I Credit.

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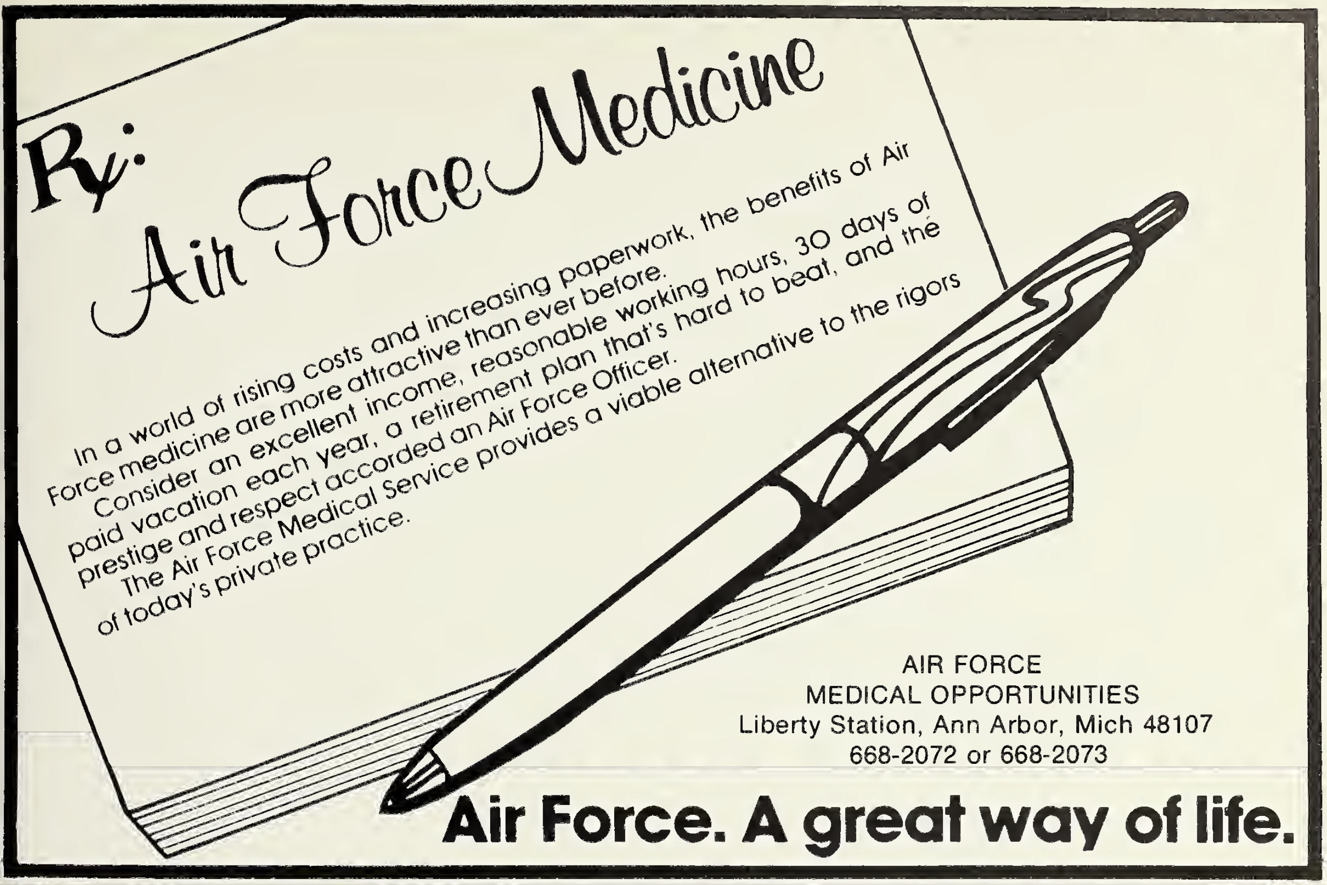
MSMS Co-Sponsored Events

The MSMS Committee for CME Programming has agreed to co-sponsor the following events. MSMS members will be permitted to attend, provided they pay any tuition charges, meal costs, etc.

MARCH 15: Michigan Allergy Society program on "Pulmonary Mechanisms with Prostoglandin Analogues: What is Their Clinical Future," cosponsored by MSMS Committee for CME Programming, Long's Convention Center, Lansing. One hour of Category I credit. For details write Clyde Flory Jr., MD, 201 W. Hillsdale, Lansing.

MAY 17: Michigan Allergy Society program. Presentations by residents, "Allergy-Immunology Research Papers," cosponsored by MSMS Committee for CME Programming. Henry Ford Hospital, Detroit. Two hours of Category I Credit. For details write Clyde Flory Jr., MD, 201 W. Hillsdale, Lansing.



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Joseph J. Tiziani, M.D.
Prehlad S. Vachher, M.D.
Angela Wallenbrock, M.D.
Richard D. Watkins, M.D.
Robert M. Zimmerman, M.D.

Doctor, you can earn CME credits at home with these helps

By Marcelyn Ireland
MSMS Staff

Physicians without access to accredited continuing medical education facilities may earn Category I credit by various home study courses. These courses are available in a variety of packages — journals, cassettes, self-assessment tests — with as varied sponsorship.

Activities that have been designated as acceptable for the AMA Physician's Recognition Award will be accepted for Michigan relicensure requirements, provided the activity is completed as designed.

Pharmaceutical firms (Smith, Kline and French, and Hoechst-Roussel) have packaged courses for Category I credit. Ask your drug representative about current or anticipated CME offerings.

Some courses are adaptable for use by groups in clinical conferences or continuing medical education sessions for credit for each participant. Non-accredited hospitals may use this material in their regular conferences for occasional Category I hours. Inquiry for specific followup requirements should be directed to the sponsoring organization.

Listed below is a sample of courses available for home study. Each participant should judge the content of courses and verify Category I status of individual titles. Additional sources of audio programs are listed on page 825 of the August 15, 1977 *Supplement to JAMA*.

- American Academy of Ophthalmology and Otolaryngology, 15 Second St., SW, Rochester, MN 55901.

  Otorhinolaryngology – Self Improvement Program, *1977.* 8 clinical simulations for self-assessment and self-instruction. 32 hours.

  Ophthalmology. Video cassettes, abstracts, post-tests, 3 hours.

  Otolaryngology. Video cassettes, abstracts, post-tests, 3 hours.

- American Society of Contemporary Medicine and Surgery, Box 837, Acton, MA 01720.

  Comprehensive Therapy. Journal, 5 hours per issue.

- American Medical Association, Division of Continuing Medical Studies, 535 North Dearborn, Chicago, IL 60610.

  CME Video Clinic Series. Video tape, syllabus, tests, Various titles. 3-6 hours.

- Biomedia, Inc., Box 251, Princeton, NJ 08540.

  Radiology. Audio cassette. radiographs, post-test. 40 hours.

  Weekly Psychiatry Update Series. 52 lessons with post-tests. 39 hours.

  Weekly Urology Update Series. 40 lessons with post-tests. 40 hours.

  Weekly Anesthesiology Update. 40 lessons with post-tests. 40 hours.

- Career Teacher Training Center, Room 109-D, Baylor College of Medicine, 1200 Moursund, Houston, TX 77030.

  Diagnosis & Evaluation of the Drug Abusing Patient for Treatment Staff Physicians. Monograph with pre and post tests. 4 hours. Other titles available.

- College of Physicians of Philadelphia, 19 South Twenty-Second Street, Philadelphia, PA 19103.

  Practice *Related Educational* Program *(PREP).* Practice survey forms, self-assessment, audiotapes. 20 hours.

- Continuing Medical Education Programs, Johns Hopkins University Press, Baltimore, MD 21218.

  Highlights of the Topics in Clinical Medicine. Audio-tape cassettes, syllabus, slides and tests. 2 hours.

- The Digests, 444 Frontage Road, Northfield, IL 60093.

  The Journals of Continuing Education –

  Family Medicine
  Orthopedics
  Dermatology
  Pediatrics
  journals, 2 hours.

  Cardiology
  Psychiatry
  Obstetrics & Gynecology
  Pharmacy

  Ophthalmology
  Clinical Medicine
  O.R.L. & Allergy
  Urology

- The Ohio State University Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 West Tenth Avenue, Columbus, OH 43210.

  Ohio Medical Education Network (OMEN). Small group two-way physician discussion network.

- Network for Continuing Medical Education (NCME), 15 Columbus Circle, New York, NY 10023.

  Various titles. Cassette, self-assessment quiz. Hour for hour credit.

- University of Michigan Media Library, Towsley Center for Continuing Education, Ann Arbor, MI 48104.

  Various titles. Cassette, self-assessment quiz. Hour for hour credit.

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*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. ntramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular dministration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted. Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

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Medical school enrollments increase in 1977

Total enrollment in the 116 U.S. medical schools in 1976-77 was 58,266, an increase of 2,022 over the previous year, says the American Medical Association's 77th annual report on medical education published in the Dec. 26 issue of the Journal of the American Medical Assoication.

First-year enrollment increased from 15,351 in 1975-76 to 15,667 in 1976-77, the AMA reports. The number of graduates increased from 13,561 to 13,607.

The total number of women enrolled in 1976-77 was 13,059, an increase of 1,532 over the previous year.

There were 41,394 full-time faculty members in the schools in 1976-77, for a ratio of 1 teacher for each 1.4 students. In addition, more than 80,000 physicians and others taught part time.

The total new enrollment of 15,667 students was selected from a total of 42,155 applicants. For the second time in as many years, the number of applicants declined slightly, from the peak of 42,624 in 1974-75. Each applicant applied to an average of almost nine different schools at the same time, hoping for acceptance by at least one.

By 1981-82, the 116 medical schools projected a first-year class of more than 16,000, with more than 16,000 graduates each year. Some additional medical schools will be in operation by that time.

Ethnic minorities enrolled in medical schools in 1976-77 totalled 4,841, a percentage of 8.2 per cent.

Family medicine is now offered as a distinct discipline in 102 of the 116 medical schools.

In the field of graduate medical education, there was a decrease in the number of foreign graduates serving in house staff positions in U.S. hospitals. Total at the start of 1977 was 15,097. There were 42,903 graduates of U.S. medical schools serving as interns or residents.

Meetings

(See also listing of Category I programs on page 108)

Feb. 24-Mar. 3 — Michigan Doctors Study club, Study/Ski Seminar, Vail, contact: Thomas R. Berlund, MD, c/o M. Guerin Tours, Inc., P.O. Box 868, Port Huron, MI 48060, 313/987-7370.

March 8-9 — Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Herbert Auer, MSMS headquarters.

March 24-31 — Michigan Doctors Study Club, Study/Ski Seminar, Snowmass, contact: Thomas R. Berglund, MD, c/o M. Guerin Tours, Inc., P.O. Box 868, Port Huron, MI 48060, 313/987-7370.

April 13 – "The Physician's Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

April 13 — Medical Aspects of Organized Athletics, Hilton Inn, Lansing, contact: Herb Auer, MSMS headquarters

April 18 — Annual Legislative Day, MSMS Auxiliary, Olds Hotel, Lansing, contact: Mrs. Thomas Berglund, 618 Aquaview Drive, Kalamazoo, 49009.

April 21 — 28th Annual Meeting, State of Michigan Branch, American Association of Medical Assistants. Michigan Inn, Southfield, contact: Donna Fogal, AAMA branch president, 1306 Eighteenth St., Port Huron, 48060.

May 1-3 — MSMS Auxiliary annual convention, MSMS Auxiliary, Bay Valley Inn, Bay City, contact: Helen Schulte, MSMS headquarters.

May 5-7 — Annual MSMS House of Delegates meeting, Hyatt Regency Dearborn, contact: Dick Campau, MSMS headquarters.

June 15 — "Insurance Programs for Family Protection and Retirement Income," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

June 17-22 — AMA Annual Meeting, St. Louis.

June 19-29 — MSMS Rhine Adventure, Contact: Marcelyn Ireland, MSMS headquarters.

Sept. 14 — "Legal Problems of Ending Medical Practice," presented by St. John Hospital, Dept. of Health Education in Cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Oct. 8 — MSMS Eastern Mediterranean Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Oct. 12 — "Pre- and Post- Retirement Medical Care for the Physician and His Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

***Nov. 7-9* — Annual Scientific Meeting, sponsored by MSMS, Detroit Plaza Hotel, contact: Herbert Auer, MSMS headquarters.**

Nov. 23 — "How Do I Know When to Retire?" presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Here's definitive description of disability determination system

By Harry D. Nesmith, MD Lansing

Death and taxes may be certain in your life, Doctor. But I submit that so, also, may be queries for information from the Disability Determination Section of the Social Security Administration.

The Social Security Program has been a part of our life since August, 1935. In 1954, Congress recognized many workers were forced to cease work prior to their sixty-fifth birthday due to disabling conditions, and consequently became dependent on their families, private institutions, or public welfare. In 1956, the Disability Program of the Social Security Administration was expanded to provide cash benefits to workers at age 50 if and when disabled. Now cash benefits are no longer limited to claimants over 50, except in the case of disabled widows.

Eligibility for cash benefits to disabled individuals includes workers or the self-employed, insured under Social Security, who meet the definition of disability. These applicants are entitled to monthly cash benefits after a five-month waiting period. "Disability" under Social Security means the inability to work because of a physical or mental impairment that has lasted — or is expected to last — at least 12 months, or is expected to result in death.

The Bureau of Disability Insurance primarily concerns itself with two categories. One is the Title II Disability Insurance Program which was passed by Congress in 1954 and implemented in 1955. The other is the Title XVI or Supplemental Security Income Program which was established by law in 1972 and implemented in January 1974. Applicants for Title II disability benefits are persons, their dependents or survivors, who (A) have been employed in work covered by the Social Security Act, and (B) allege they are disabled physically or mentally and are now unable to work. Applicants for Title XVI benefits are those who have established they are needy and in addition claim to be disabled. This applicant may have never been gainfully employed. Children may be included in this group — children who have such severe impairments that they cannot attend school — are unable to relate to other children in a normal way and consequently can be expected to live with a handicap of substantive magnitude.

The applicant files for disability at a District Office of the Social Security Administration. An interview is completed with a claims representative and an initial claim form is "filled in" giving many salient features of the claimant's allegations. Included will be names of physicians, clinics, hospitals and laboratories which then will be used to either allow or deny the claim.

Doctors determine disability

Disability determinations are made to a major extent upon the information submitted by doctors. Bona fide evaluation and judgment depend upon objective evidence which delineates the presence of a physical or mental impairment, the quality of severity, the duration, and the effect on the applicant's functional capability to be gainfully employed. The histories and physicals must be limited to the report of history, physical and clinical data, diagnosis, prognosis, treatment, and response. The documents must be specifically directed toward the quantification of extent of residual functional capacity in the

physicians, consider a practice in **south carolina**.

* low malpractice insurance rates, * the opportunity to join a group or partner or establish a new practice in a rural or urban area, *continuing medical education through a system of Area Health Education Centers, as well as two medical schools, * lower taxes, * lower cost of living, * access to both mountains and beaches, and * a mild climate

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Columbia, S.C. 29211
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affected parts and should avoid any references and opinions as to the existence of disability.

It is so simple when the description of the impairment is done with such clarity that the independent examiner can deduce the same decision as the person preparing the document.

Should you receive a query concerning medical findings on your patient, please send any germane information that you have as promptly as possible to the State Agency originating the request. If you have no record of any condition, a negative report is appreciated.

Disability determinations are made in each of our States by an agency known as the DDS, (Disability Determination Section). The adjudications are made by physicians and trained disability examiners using the information submitted by treating or consulting physicians who have examined the claimant.

Two diverse situations

Our Regulations specify the determination must be made from all the facts of the case. Primary evaluation is directed toward the severity of the individual's impairment; and consideration also is given to other factors, such as the claimant's age, education, training, and work experience. Medical consideration may be the sole determinative factor in the issue of "disability" in two diverse situations:

A. Denial is in order where the sole impairment is qualified as "slight," or even a combination of slight abnormalities are present. If an impairment deviates from normal in only a trivial or superficial manner, it is not logical to assume that this factor will contribute significantly to the rationality of why the individual is not working.

B. A case may be allowed where the impairment would ordinarily be considered as preventing substantial gainful activity. Examples are:

1. Loss of use of two limbs.
2. Certain progressive diseases which have ultimately caused the physical loss, anatomically of functionally, of a limb, such as diabetes mellitus, multiple sclerosis or Buerger's disease.
3. Diseases of the heart, lung, or blood vessels which have resulted in major loss of heart or lung reserve as evidenced by laboratory testing, as well as producing clinical manifestations of shortness of breath, pain or fatigue on slight exertion. Examples are walking short distances, climbing stairs, using public transportation or doing small chores.
4. Cancer which is inoperable.
5. Damage to central nervous system, or brain abnormality which has caused severe loss of judgment, intellect, orientation or memory.
6. Mental disease, either psychosis or severe psychoneurosis, requiring continual institutionalization or constant supervision of the affected individual.
7. Loss or diminution of vision to the extent that the affected individual has central visual acuity of no better than 20/200 in the better eye after best correction, or has an equivalent concentric contraction of his visual fields.
8. Permanent and total loss of speech.
9. Total deafness not correctable by a hearing aid.

In those cases where an individual has been gainfully employed despite severe impairment, but is no longer working, his case is evaluated under another concept (work despite severe impairment). An allowance of disability is indicated when current unemployment is caused by increased severity of the impairment, new impairments occur even though they are not severe enough in nature to constitute disability, special dispensations are lost in the work milieu, the individual's capacity deteriorates for engaging in work in competition with others due to age, or work experience preceding the onset of severe impairment, and while under its limitations, does not readily qualify the individual to find and perform work under new circumstances.

A second evaluation would include specifically those cases which fall between the two levels of severity previously described. The adjudication of these cases is not on a basis of medical information alone. The primary question: "Is the individual medically unable to do the work he has been doing?"

One special category

There is one category which will be mentioned for completion of the picture. It is the special emphasis to non-medical factors in the case of the older, unskilled, arduous worker. Where an individual with a marginal education and long work experience (35 plus years) spent in the performance of arduous, unskilled, physical labor is not working and is no longer capable of performing such labor because of a significant impairment or impairments and, considering his age, education, and vocational background is unable to engage in lighter work (no transferable skills), such an individual may be found under a disability.

Other cases which do not meet the listings as prescribed by law, constitute what are termed "borderline cases." As the regulations delineate, it must be primarily established that the person's impairment is of such severity that it precludes the performance of prior, usual, or regular work.

One would logically deduce that if applicants can perform their regular work, their claims would be denied. If unable to perform regular work, one must ascertain whether the impairment, in conjunction with age, education, training and experience, establishes the individual is unable to engage in any other type of substantial gainful activity. These decisions require close scrutiny and consideration, and use all the expertise present on the determination team both in evaluation and in developing the needed information for a proper and just determination. There is a need for full and complete description of all essential aspects of the case.

Doctor Nesmith is Chief Review Physician, Disability Determination Section, Social Security Administration, Michigan State Agency. ◥

Deaths

Earl R. Addison, MD
Crystal Falls

Earl R. Addison, MD, 63, well-known Iron County physician, died Nov. 17. Doctor Addison received his medical degree from the University of Wisconsin and was affiliated with Crystal Falls Municipal and Iron County hospitals, Crystal Falls. He was a past president of the Dickinson-Iron County Medical Society and a member of the American Academy of Family Physicians.

H. Erwin Cope, MD
Lansing

H. Erwin Cope, MD, Lansing, former chief of the clinical pathology section for the Michigan Department of Public Health, died Dec. 10 at the age of 83. Doctor Cope was granted his MD degree from Rush Medical College, Chicago. He was a past president of both the Michigan Pathological Society and Ingham County Medical Society, and also held memberships in the Michigan Branch of the Society of American Bacteriologists and the Michigan Trudeau Society. He was a diplomate of the American Board of Pathology. He was a staff member of both St. Lawrence and Sparrow hospitals, Lansing.

(Correction: *Michigan Medicine* deeply regrets the publication of an obituary in the January issue for Christopher H. Southwick, MD, Grand Rapids. C. H. Southwick, MD, is alive and well. An obituary for his father, the late C. Howard Southwick, MD, correctly appeared in the same issue.)

Frederick M. Doyle, MD
Kalamazoo

Frederick M. Doyle, MD, 75, Kalamazoo, died Dec. 6. A graduate of the University of Michigan Medical School, Doctor Doyle was a member of the American College of Chest Physicians as well as the American Academy of General Practice, and was a past president of the Kalamazoo Academy of Medicine. He was former chief of staff at Borgess Hospital, Kalamazoo.

James D. Klauer, MD
Mt. Pleasant

James D. Klauer, MD, Mt. Pleasant, died Sept. 28 at the age of 44. Doctor Klauer, a radiologist, obtained his medical degree from the State University of Iowa, Iowa City.

Charles C. Merkel, MD
Grosse Pointe

Charles C. Merkel, MD, a Grosse Pointe otolaryngologist, died Oct. 1 at 78 years of age. Doctor Merkel was a graduate of the University of Michigan Medical School and was a member of the American Academy of Ophthalmology and Otolaryngology.

Albert F. Milford, MD
Ypsilanti

Albert F. Milford, MD, Ypsilanti, died Nov. 13 at 68 years of age. Doctor Milford received his medical degree from the University of Michigan Medical School and was a member of the staffs of Beyer Memorial and St. Joseph Mercy hospitals. He was founder of the Milford Clinic, the first non-hospital emergency medical service in the area. For his contributions to the community through his emergency medical service, the Ypsilanti Junior Chamber of Commerce honored him with its Outstanding Citizen Award.

Nathan Sinai, MD

Nathan Sinai, MD, 83, formerly of Ann Arbor and a leading figure in the fields of health insurance and public health economics, died Nov. 28. Doctor Sinai was professor emeritus of public health at the University of Michigan and president of the World Health Foundation. He was director of the University of Michigan Bureau of Public Health Economics, which he founded. Doctor Sinai established the first university course in medical care administration. A consultant to the World Health Organization, which he directed at the time of his death, Doctor Sinai also was director of research of the Michigan State Medical Society and a consultant to the Ann Arbor Health Department. He was a fellow of the American Public Health Association and former president of the Michigan Public Health Association.

Eugene C. Timmerman, MD
Coopersville

Eugene C. Timmerman, MD, 68, Coopersville, died Oct. 9. Doctor Timmerman graduated from the University of Michigan Medical School and was past chief of staff of Municipal Hospital, Grand Haven. He was a member of the American Institute of Hypnosis.

Rita B. Tower, MD
Flint

Rita B. Tower, MD, Flint, died Dec. 21 at the age of 85. A graduate of the University of Michigan Medical School, Doctor Tower was a member of the American Thoracic Society and the Michigan Tuberculosis and Respiratory Disease Society. She was a medical missionary in India and also devoted many years to the Genesee County Tuberculosis Sanatorium.

Morris A. Wayne, MD
Detroit

Morris A. Wayne, MD, a Detroit physician specializing in industrial practice, died Dec. 20 at the age of 78. A graduate of Wayne State University School of Medicine, Doctor Wayne was affiliated with Sinai and Brent hospitals, Detroit. He was a member of the Industrial Medical Association.

Cyril A. Youngs, MD
Kalamazoo

Cyril A. Youngs, MD, of Kalamazoo, died Dec. 15 at the age of 85. A graduate of Northwestern University School of Medicine, Illinois, Doctor Youngs was affiliated with Borgess and Bronson hospitals, Kalamazoo, where he was a member of the surgical staffs.

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Registration Fee: $200 non-member physicians; $100 military; $100 registered nurses; Complimentary: students, residents, interns and Fellows.

Write or Phone: New Orleans Graduate Medical Assembly, Room 1538, Tulane Medical Center, 1430 Tulane Ave., New Orleans, LA 70112. Call (504) 525-9930.

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Spring Fiesta, March 31, 1978. "A Night in Old New Orleans", Jackson Square.

Classified

Positions open

OPHTHALMOLOGIST, relocating, desires to sell office and practice, $80,000 gross yearly. Area near Western Oakland County. Growing practice, excellent location two blocks from hospital. Very rapidly growing area. Patient load can be easily doubled. Please reply to Michigan State Medical Society, 120 W. Saginaw, Box 4, East Lansing, MI 48823.

DIRECTOR — RESIDENCY PROGRAM to assume responsibility for development and direction of Family Practice Residency Program. Qualifications: Doctor of Medicine degree and experience in Family Practice or resident teaching. Our Residency Program is affiliated with Michigan State University College of Human Medicine. Excellent salary and benefit package. St. Lawrence Hospital is a 287-bed, acute care facility located in Lansing, Michigan. Convenient to two major universities and year 'round recreational facilities. Please send resume to: Gordon R. Harrod, MD, Acting Director, Family Practice Residency Program, St. Lawrence Hospital, 1210 W. Saginaw St., Lansing, MI 48914.

TIRED OF ICE AND SNOW? COME SOUTH! Need all specialties. Situations available in all southern states. Immediate need for primary care physicians in NC, SC, GA, ALA, MISS, TN. Most are groups providing office, equipment, insurances, retirement program, profit sharing, and other perquisites. Salaries $50-60K range. OUR FEE IS PAID! Send CV with details to Medical Search, 3274 Buckeye Road, Atlanta, GA 30341.

F.P.'s NEEDED — Growing community of 4000+ needs one or two MDs, two F.P.s in town and one nearby. Join existing practice or solo available. Excellent recreation and economy. Sixty miles from metro cities, 57 bed J.C.A.H. hospital in community. Trade area of 12,000+ U.S. grad preferred. Contact L. Wattier, Administrator, Memorial Hospital, Inc., 104 W. 17th, Schuyler, NE 68661, 402/352-2441.

INDUSTRIAL PHYSICIAN — A vacancy exists in the expanding staff of the Detroit Industrial Clinic, P.C., for a physician with at least three years experience. Background in Surgery, Emergency Room or Industrial Medicine is most desirable.

We offer a competitive salary, liberal life insurance, major medical insurance and a pension program.

Please contact: Robert A. Silver, M.D., Detroit Industrial Clinic, P.C., 20755 Greenfield Road, Southfield, Michigan 48075; (313) 569-5144.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park there are openings for physicians trained as Internists, Family Physicians or Psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently over $40,000 per year, plus 23% fringe benefits, including life, accident, long-term disability, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, Michigan 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7789.

MEDICAL DIRECTOR — licensed M.D. or D.O. in Kalamazoo, Michigan. 40-hour week, no weekends, leisurely work doing physicals and reviewing charts. All malpractice paid, $30,000/yr. salary. Contact: Daniel Idema, V.P. of Operations, American Plasma Mgmt., Inc., 705 N. Park St., Kalamazoo, Michigan 49007, phone 616/245-9855 in Grand Rapids, MI.

PSYCHIATRISTS: Join well-run CMHC with proven professional programs. Do IP, OP, crisis, consultation. Possible academic appointment, new center. Stable funding, salary and fringe package high 30's to low 50's. Live in navy bean, sugar capital of Midwest, manufacturing center, international seaport, great cultural, educational, recreational area. Call or write Director, Saginaw CMHSC, 1314 S. Jefferson Avenue, Saginaw, MI 49601. Phone 517/752-4178.

DIRECTOR OF EDUCATION IN INTERNAL MEDICINE. A certified internist or subspecialist is needed for an administrative and teaching position in an Internal Medicine residency program affiliated with Michigan State University College of Human Medicine and Hurley Medical Center. McLaren General Hospital is a 469 bed, progressive, acute care hospital with general surgery, internal medicine, orthopedic, ob-gyn, and psychiatric training, and an undergraduate teaching program. Salary negotiable. Community offers excellent recreational and cultural opportunities. Inquiries to: Search Committee, c/o Mr. Gary R. Peterson, McLaren General Hospital, 401 Ballenger Highway, Flint, Michigan 48502, 313/762-2345 or B. S. Farah, MD, Chairman, Dept. of Internal Medicine, McLaren General Hospital, 401 S. Ballenger Highway, Flint, Michigan, 48502, 313/235-6663.

Positions wanted

PHYSICIANS ASSISTANT will graduate in October 1978 from an AMA accredited program specializing in primary care. 27-year-old male, married with two children. Have experience as senior medical corpsman for six years and 1½ years in a professional nursing school. Would like to practice in western or northern Michigan, but all opportunities considered and appreciated. For more information, call 314/445-7233 or write Daniel E. VanderMolen, 4454 Bellview, Apt. C, Columbia, MO 65201.

WANTED: To buy medical practices in Detroit or suburbs. Will buy all equipment, buildings and employ seller if desired. Trail Clinics, P.C., 313/861-4400, Cindy Papuga, Clinic Secretary.

Miscellaneous

LAKE SUPERIOR FRONTAGE, at Big Bay, near Marquette. New modern year-round residence, plus four lakefront lots. Sand beach. An investment to enjoy. Maintained county road, electricity, telephone. Top hunting, fishing area. Sell all or part. VACATIONLAND REALTY, 407 Northland Towers W., Southfield 48075, 313/569-6302.

BEAUTIFUL, rustic year-round cabin located in Central Eastern Upper Peninsula, includes 160 acres with 20 acre tree plantation, large fireplace, fully insulated, sleeps ten, separate sauna, completely furnished, good roads, excellent hunting, ideal for club or investment, contact Buckingham Real Estate, 224 Newberry Avenue, Newberry, Michigan 906/293-8771.

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Numbers 2 and 3 could be combined into one office. All utilities are included. We have specific need in the areas of opthalmology, gynecology, and general practice and we will help you get started. Visit our beautiful facility and our friendly village. Douglas F. Kirby, DDS, P.O. Box 151, Richland, MI 49083, 616/629-9087.

FOR SALE — Doctor's home and office, fully equipped, excellent brick building on two city lots and on corner, with separate address. Office equipment, examining tables, two regular and one adjustable, sigmoidoscope, refrigerator, autoclave, desks and usual instruments all included in the purchase price. X-ray and laboratory facilities nearby. Shown by appointment. Call E. F. Lewis, MD, 1112 Carlton Blvd., Jackson, Michigan 49203, (517) 782-7134 (office), or (517) 782-4471 (home).

FOR RENT: Reception room, business office, two treatment rooms, lab and restroom. Excellent location. 15 Mile Road, west of Gratiot, Mt. Clemens, Mich. Contact Charles C. Milonas, DDS, 313/791-1600.

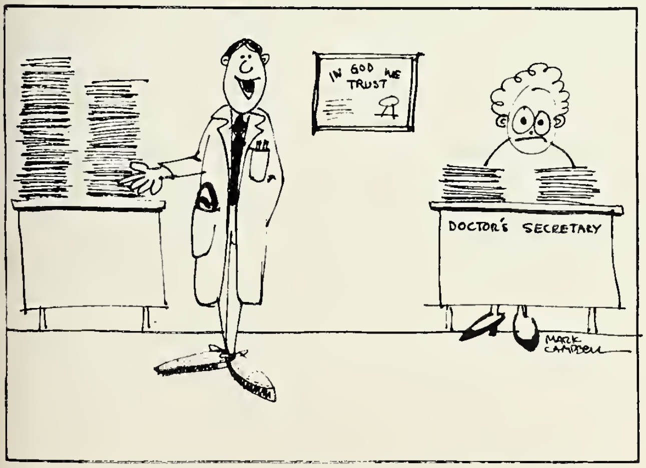
SIX MEDICAL OFFICE SUITES — all new medical center in prime location of Brighton. 1150 square feet to 3000 square feet office units, includes four exam rooms or more, private office and entrance, laboratory, excellent parking, ideal to accomodate one or two doctors. Spring or summer occupancy. Call Davis Professional Bldg., 313/229-2752 or 313/229-7525.

METAL PLAQUE — Honorary certificates, diplomas, photos, etc. perfectly reproduced in bright silver toned metal with black lettering, all the clarity of the original yet immune to deterioration. Mounted on richly finished walnut base 10 x 12 for only $39.95. Allow four weeks. Perma-Plaque, 778 Rivard, Grosse Pointe, MI, 48230, 313/884-9399.

AMA's newest version of CPT now available

Thirty-eight revisions are included in the first update to the fourth edition of CURRENT PROCEDURAL TERMINOLOGY, the American Medical Association's comprehensive system for naming, coding and reporting medical procedures and services.

The Fall 1977 update to CPT-4 includes the following changes:



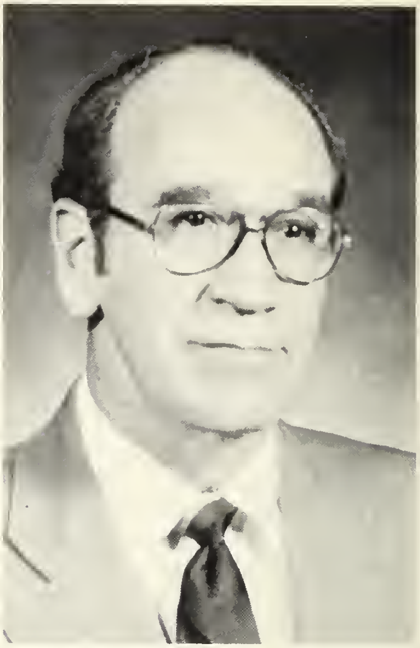
Good news, here are the new special improved 879 page insurance forms which replace the old 623 page insurance forms.

- The most extensive revision deals with mastectomy. CPT-4 now includes both delayed and immediate prosthetic implants after radical or modified radical breast surgery.
- In foot surgery, radical resection for tumor is more clearly defined. In addition, sesamoidectomies are now coded.
- In dermatology, chemical cauterization of a wound and photochemotherapy with ultraviolet are now listed.
- Newly coded procedures in other fields include cryosurgery of turbinates, bone marrow transplants, and nonpressurized airway inhalation treatment.
- In addition, several procedures were deleted, i.e., introduction of intraosseous needle and one of the entries for two-stage transurethral resection of prostate.

The first updates have been sent this month to individuals who have completed and returned the prepaid card included in the CPT-4 book. This and future updates to CPT-4 are provided at no additional cost to CPT-4 purchasers.

CPT is available through the Order Department, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610. Single copies are $12 each.

We must pay and support MDs to serve on planning boards



Doctor Fryfogle

By James D. Fryfogle, MD
Detroit

In the health planning field we need able, articulate, skilled, knowledgeable, and perceptive men who understand the ethical tenets of the medical profession. They should be paid and furnished adequate staff to represent organized medicine.

Organized medicine could take a lesson from labor and industry in the approach to federal health care planning.

As part of their job, executive personnel of industry sit and serve on many health care planning commissions and boards. Officials of organized labor spend a large percentage of their working day at all levels of federal, state and local health planning.

The importance of control and guidance of health care planning agencies is recognized by industry and by unions. They allocate high-level personnel to the work of these agencies. Their representatives' schedules permit them to attend meetings at all times, to serve on special committees, to attend conferences and serve as officers, and they are provided with back-up staff.

Physicians' time limited

Since no alternates are allowed on our local health planning boards, the practicing physician finds it impossible to attend the many meetings. Thus the voice of medicine is not always considered in final decision-making.

We, organized medicine, send harried private practitioners with their on-call beepers, who arrive late, sometimes have to leave early, who cancel appointments and operations to attend the meeting, and who may have spent minimal time in preparation. We can not criticize these doctors, but appreciate and wonder at the amount they accomplish in spite of their demanding schedules. While this problem of scheduling doctors' time affects all committees, boards of charitable organizations, insurance companies and government commissions, it is particularly important in federal health planning decisions.

Here, the very existence of the practice of medicine as we know it today is under siege.

Our relationship with our patients, with our hospitals, with our educational programs, with all paramedical personnel and their training, with the variety of federal and state financial programs, with legal involvement, is being questioned and challenged and changed.

Doctors, perhaps, are too patient-oriented. They have of necessity too much personal involvement with patients, their immediate problems, their families and their neighborhoods.

Planners, per se, think in more general terms. They are concerned with all ramifications of problems related to health, sociological problems over which there is little control (by any measure), and certainly none by doctors. Planners want a tightly-bound system of control of all things related to health, for all people, now and forever — *and*, they have the money and the power to completely change the system as we now know it. ◥

ROCHE

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Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

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- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

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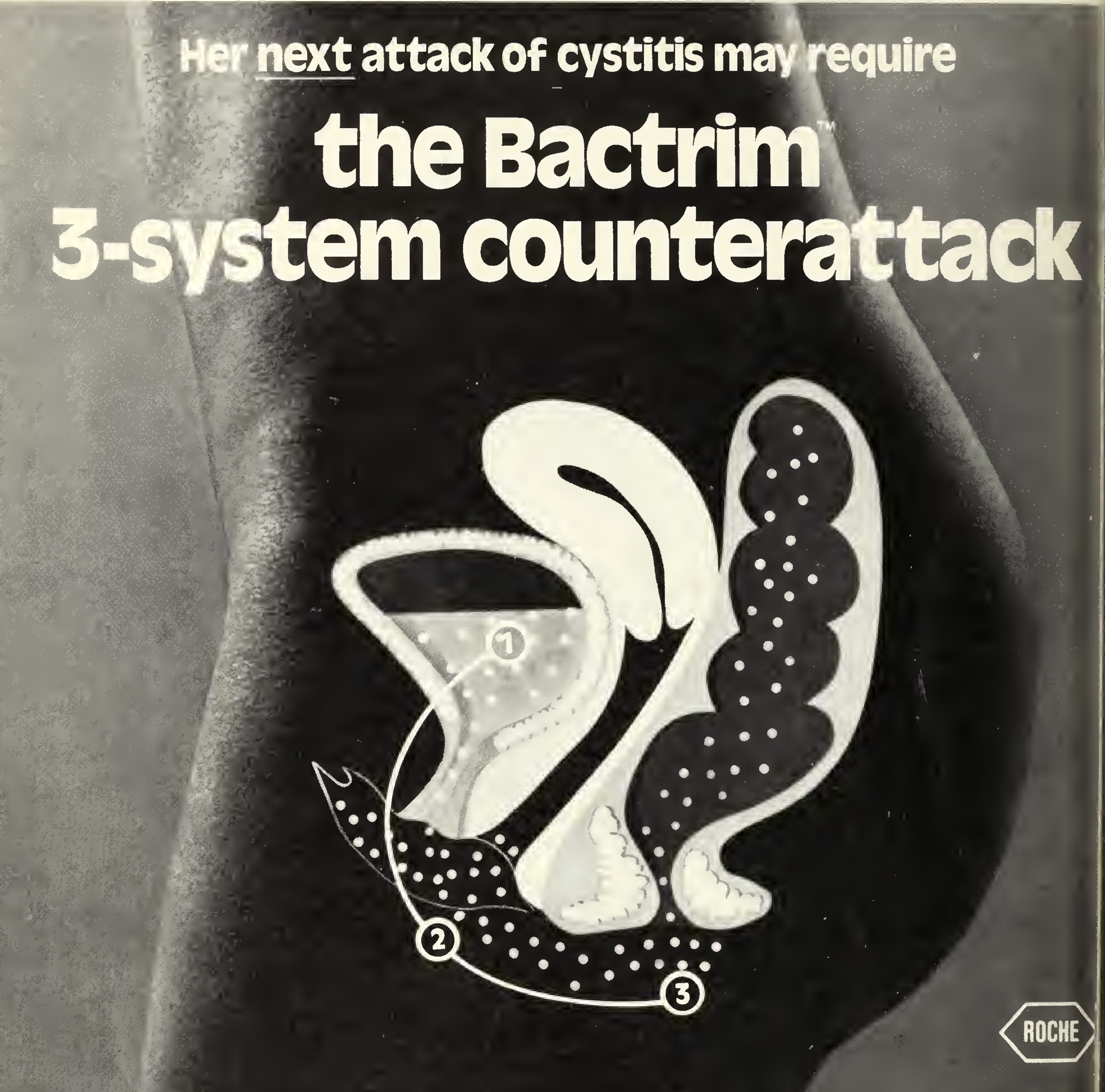
Her next attack of cystitis may require

the Bactrim™
3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enter* *bacteriaceae* in the bowel without the emergence of res tant organisms. Thus, Bactrim reduces the risk of intro colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the
urinary tract/vaginal tract/lower intestinal trac

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 6 FEBRUARY 20, 1978

CAPSULES

Inserted in this Medigram is a special newsletter of the Michigan Doctors Political Action Committee. Printed on green stock, the newsletter brings MSMS members the latest information on MDPAC growth, current activities and auxiliary work.

* * *

Thirty-eight percent of MSMS members had remitted their dues for 1978 as this issue went to press. MSMS began billing members in December for county, state, AMA and MDPAC memberships. The dues this year include a $35 increase to meet MSMS legal expenses in resisting recent Blue Cross/Blue Shield of Michigan reimbursement changes.

* * *

Be sure to read the February issue of Michigan Medicine, suggests James Tisdel, MD, Port Huron, chairman of the MSMS Publication Committee, and especially read the excellent articles about health care planning in Michigan. "And don't miss the special articles by MSMS President Vernon V. Bass, MD, Saginaw, and Speaker of the MSMS House of Delegates James B. Fryfogle, MD, Southfield."

* * *

Page 3 of this issue is devoted to program information and a registration form for the 1978 MSMS-sponsored Michigan Maternal Health Conference. The big meeting, which annually attracts about 800 Michigan doctors and nurses, is scheduled March 8-9 at the Hyatt Regency Dearborn.

Maternal Health Conference soon; registration form inside

An estimated 800 physicians and nurses will attend the 17th Annual Michigan Conference on Maternal and Perinatal Health, March 8 and 9 at the Dearborn Hyatt Regency.

Program information and a registration form appear on Page 3.

Physicians attending may earn a maximum of six hours of Category I Credit on Wednesday, March 8 and up to five hours on Thursday, March 9, according to Bruce A. Work, Jr., MD, Ann Arbor, general chairman.

This year the conference is for two full days, presented jointly by MSMS, the Perinatal Association of Michigan and the Michigan Section, Nurses Association, American College of Obstetricians and Gynecologists, District V. The conference committee, with representatives of all three organizations, planned the two days as one integrated conference dealing with "Changing Concepts."

Traditionally this conference moves from various areas of the state after two years, and it shifts now to the Detroit area after two years at the Kalamazoo Center Inn.

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MSMS gathers own Blues data

Over 31 percent of MSMS members responding to a survey just completed by the MSMS Bureau of Economics say they participated at one time in their careers with Blue Cross/Blue Shield of Michigan, but are not now participating. This is believed by the researchers to be perhaps the most significant finding of the survey, which was initiated by the Bureau to gather MSMS data in light of the recent reimbursement changes made by the Blues. Full details of the survey are published in the March issue of Michigan Medicine, in connection with a special section on the growing research activities of MSMS.

Appointments should be completed in April to the new Michigan PSRO Statewide Council. Michigan is the 11th state to qualify for a statewide council, now that all 10 Michigan PSRO areas have been started. The Statewide Council will coordinate the regional PSRO activities. The Council is expected to be functioning by early fall.

* * *

A Louisiana attorney has filed what is believed to be the first "counter-countersuit" to date. Attorney Harry Burglass filed the suit June 30 in a Louisiana district court against a New Orleans pediatric surgeon who earlier had taken Mr. Burglass to court for filing an unfounded malpractice suit. That countersuit was eventually dismissed for failure to state a claim. Mr. Burglass is seeking $902,500 from the surgeon and her lawyers. AM News, Aug. 1, 1977, at 1, col. 2.

* * *

"Housecall," the monthly call-in medical program on Channel 56, Detroit, sponsored jointly by the Wayne, Oakland, Macomb county medical societies and MSMS is being seen on Tuesday, Feb. 21 this month instead of the normal third Thursday evening due to a station preemption. Doctor panelists appearing on the 9:30 p.m. program include Mary Kokoski, MD, neonatologist at Beaumont Hospital; Richard Gallucci, MD, family physician from Dearborn and Richard Gascoigne, MD, general surgeon, Adrian. "Housecall" will not be seen during March because of preemption of air time for the public broadcast station's annual fund-raising activities.

MSMS planning 1978 Scientific Meeting

Plans are advancing on schedule for the 1978 MSMS Annual Scientific Meeting which will be held at th Detroit Plaza Nov. 7-8-9, according to Robert F. Wilson, MD, Detroit, program chairman, and Carl F. Hammerstrom, Jr., MD, Marquette, chairman of the MSMS Committee for CME Programming. Some of the specialty societies have already reported to Docto Wilson proposed topics for half-day Category I courses, and speakers are being invited. Some new features are being developed by Doctor Wilson for the 1978 meeting, which will shift to the Detroit Renaissance Center after two successful scientific meetings at the Dearborn Hyatt Regency. Progress reports will be considered at the March 16 meeting of the CME Programming Committee.

Tests can't link problems to PBB

Intensive medical evaluations have been completed on 46 persons exposed to PBB and who have had health problems, according to the Michigan Department of Public Health. The tests were done in University Hospital, Ann Arbor, and Henry Ford Hospital, Detroit, as part of the Department's PBB long-term study.

Physicians working with the participants since hav informed them by letter:

"1. There was agreement among the physicians that all did have health problems.

"2. Some of the problems found were similar to those seen in the general population and varied from person to person. Recommendations have been made concerning these where it was appropriate.

"3. Some people had health problems that were not common in the general population, such as, weaknes, inability to work or concentrate for long periods, joint or muscle pain, and slight liver enlargement Treatment for these conditions is not known at this time. The physicians involved in the examinations have discussed and are formulating suggeste treatments for certain individuals that the physicians believe might be of benefit. These individ will be contacted at such time as these treatment are formulated.

"4. The problems found or their severity could n be related to the PBB levels. There was no patte of illness that could be related to high levels a opposed to low levels. This has been noted in other studies, and the significance of this findi is not yet clear."

Michigan Conference On Maternal And Perinatal Health

WEDNESDAY, MARCH 8

(Maximum of 6 hours Category I Credit)

7:30 Registration Begins

8:30 Morning Session in Hubbard Ballroom

Presiding: Bruce A. Work, Jr., MD, Associate Professor, Department of Obstetrics and Gynecology, University of Michigan Medical School, Ann Arbor, and Conference Chairman

8:30 Maternal Transport, Frank H. Boehn, MD, Nashville, Tenn.

9:00 Neonatal Intensive Care Unit Outcomes, Pamela Fitzhardinge, MD, Toronto, Ontario

10:00 Team Approach in Infant Transport (Preparation, Family Acceptance, Follow-up), Richard P. Gallucci, MD, Dearborn; Ronald L. Poland, MD, Detroit; Noreen O'Brien Brohl, MSW, Wyandotte; Peggy Malnight, RN, Kalamazoo

1:30 Afternoon Program in Hubbard Ballroom

1:30 Ultrasonography and the Assessment of Fetal Growth, William B. Steele, MD, Detroit

2:00 Pregnancy Induced Hypertension: Consideration of Mechanisms, Richard J. Worley, MD, Dallas

2:30 Hypertensive Disease of Pregnancy: Implications of Treatment, James Roberts, MD, San Francisco

3:15 Panel Discussion on Hypertensive Disease of Pregnancy versus Pregnancy Induced Hypertension: Mechanisms and Implications of Treatment, Harrison C. Visscher, MD, Grand Rapids; James Roberts, MD; and Richard J. Worley, MD

4:45 Adjournment

THURSDAY, MARCH 9

(Maximum of 5 hours Category I Credit)

7:30 Registration Begins

8:30 Morning Session in Hubbard Ballroom

Presiding: Patricia L. Gober, RN, Coordinator, Expectant Parents Program, Butterworth Hospital, Grand Rapids, and Chairman, Michigan Section, NAACOG

8:30 Parent-Infant Bonding, Michael T. Lamb, PhD, Madison, Wisconsin

9:00 Dilemmas in Decision Making: Decision Theory, Vincent DiLalla, Ph.D., Grand Rapids

9:30 Dilemmas in Decision Making: Decision Practice, E. James Potchen, MD, East Lansing

10:30 Birthing Centers, Martin B. Wingate, MD, Buffalo, New York

11:00 Birthing Centers, Esther Adkins, RN, Kalamazoo

11:30 Questions and Answers

1:30 Afternoon Session Hubbard Ballroom

Presiding: Daniel J. Wilhelm, MD, Practicing Pediatrician, Port Huron, and Chairman of PAM Program Committee

1:30 Fetal Alcohol Syndrome, James W. Hanson, MD, Iowa City, Iowa

2:00 Maternal Diet and Weight Gain During Pregnancy, Frank H. Boehn, MD, Nashville, Tenn.

2:30 Diabetes in Pregnancy, Martin B. Wingate, MD, Buffalo, New York

3:00 Questions and Answers

3:30 Adjournment

Hyatt Regency Dearborn

ADVANCE REGISTRATION

Please complete and mail to the MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH
Make checks payable to Michigan State Medical Society P.O. Box 950, East Lansing, MI 48823

Print Name	City	Physician	RN	LPN	Student
			(Please check one)		
______________	______________	☐	☐	☐	☐

		Physician	Nurse	Student/House Officer
Please Check:	Wednesday Sessions	☐ $10.00	☐ $5.00	☐ No Charge
	Thursday Sessions	☐ $10.00	☐ $5.00	☐ No Charge
	TOTAL	$ ______	$ ______	$ - 0 -

For the first time in history, MSMS memberships have topped the 9,000 mark. As of Jan. 31, the MSMS Department of Operations and Member Services reported that the total membership stands at 9,025. That figure includes 7,696 active members, 39 physicians in training, 684 life members, 418 retired members, and 188 members in other categories. The MSMS membership is approximately three-fourths of the total physician population of the state. AMA memberships in Michigan also increased in 1977, topping the previous year's mark by 55.

* * *

Eight more Michigan county jails are being invited to participate in the AMA-MSMS project to improve jail health care delivery. The project, funded through the AMA by the Law Enforcement Assistance Administration, is entering its third year. Michigan was one of the first of six states whose proposals for the pilot project were okayed by the AMA. Since then, all four of the Michigan jails which have improved health care programs have met the new national standards. The Michigan project is directed by Robert E. Medlar, MD, Jackson, and Richard Campau, of the MSMS staff.

Write MSMS House resolutions now

Component medical societies are being invited to prepare resolutions for the 1978 MSMS House of Delegates meeting May 5-7 at the Hyatt Regency Dearborn, according to Speaker James D. Fryfogle, MD. Resolutions must be at MSMS headquarters no later than April 5, to comply with the established 30-day deadline. Resolutions are to contain a fiscal note estimating cost when appropriate. Delegates wishing to submit a resolution may obtain an official resolution form from their component society secretary or executive secretary, or from Richard Campau at MSMS.

'Doctors of Week' in Lansing

MSMS "Doctors of the Week" have begun their week-long stays in Lansing to represent their colleagues and to serve as resource personnel to the 1978 Michigan legislature. The physicians and their spouses serve as MSMS volunteers during a week of formal and informal meetings with senators and representatives. The doctors scheduled for this spring are: John F. Fennessey, MD, Grosse Pointe; Joseph A. Barss, MD, Port Huron; Van O. Keeler, MD, Otsego; Donald B. Reinders, MD, Fremont; Howard C. Joondeph, MD, Grosse Pointe Park; M. Joseph Bowler, MD, Kalamazoo; Carl and Marjorie Gagliardi, MDs, Lincoln Park; Bernard A. Kats, MD, Saginaw; Juan V. Fayos, MD, Ann Arbor; Anne-Mare Ice, MD, Detroit; Fred Ayers, MD, Daggett; Duane E. Smith, MD, Brown City; and F. P. Rhoades, MD, Detroit.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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Managing Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 7 MARCH 6, 1978

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REGISTER INSIDE
FOR SPORTS CONFERENCE

Your registration form for the 1978 MSMS Conference on Medical Aspects of Organized Athletics appears on Page 3 of this issue. Let MSMS know soon that you will attend. Please invite your high school coaches and athletic trainers to share in the excellent program at the Hilton Hotel in Lansing. Six hours of Category I credit will be awarded.

WJR TO SALUTE MDs;
POSTER INSIDE
TO ALERT PATIENTS

Detroit's prominent radio station, WJR (760 AM), will sponsor a day themed "Here's to Your Health," March 23. Most programming for that 24 hours will focus on the medical profession. Listeners will hear about medical history and current issues, and learn of new findings, techniques and treatments. Michigan physicians will be interviewed, serve on panels and act as resources throughout the day. Alert your patients to this special day of radio programs with the handy tear-out poster on Page 2.

MSMS Council to hear report on negotiations

Top priority on the agenda for the March 8 MSMS Council meeting is a report of the MSMS Committee on Negotiations, Donald K. Crandall, MD, Muskegon, chairman. A report of the Council's actions will be published immediately after the Council meeting in the next Medigram.

Update on MSMS lawsuits

Two separate pieces of litigation currently are in Federal District Court, Detroit, as a result of physician reimbursement changes made by Blue Cross/Blue Shield of Michigan. MSMS legal counsel filed suit Dec. 23 for two otolaryngologists against BCBSM, the UAW, General Motors, Ford and Chrysler corporations. On Jan. 19, MSMS legal counsel in conjunction with the Michigan Psychiatric Society filed suit against the Blues on behalf of two Michigan psychiatrists and two psychiatric patients. Two other possible suits are in preparation.

Michigan MDs see congressmen to discuss health planning act

Two Michigan physicians joined the AMA effort Feb. 22 to resist changes in HR10460 - the federal Health Planning Extension Act. Approximately 60 physicians and medical society staff members from throughout the nation gathered in Washington, D.C., to acquaint congressmen with physician concerns with modifications in the planning act. They met with members of the U.S. House Committees on Interstate and Foreign Commerce and Ways and Means. Among the issues was certificate of need legislation for private physicians' offices. Carrying the message for Michigan doctors were Richard J. McMurray, MD, Flint, chairman of the MSMS Committee on Federal Legislation, and Aaron Warren, MD, Cassopolis, assisted by MSMS Deputy Director Bruce Ambrose.

Please post

Attention patients!

Tune in to
"Here's to your health"

WJR radio 76
AMERICA'S GREAT RADIO STATION

March 23, 1978

Twenty-four hours of programming
about medicine and your health

As your physician, I invite you, your family and friends to listen to Michigan radio station WJR (760 AM) all day March 23. WJR has chosen to work with medical doctors to offer its listeners the opportunity to learn about medical history, recent developments and health care tips; to ask questions of physicians and to discuss medical issues.

1978 Conference
Medical Aspects of Organized Athletics
Thursday, April 13, 1978
Hilton Inn, Lansing

(Saginaw Street exit off I-96)

Sponsored by Michigan State Medical Society

The Michigan State Medical Society will grant 6 hours of Category I Continuing Medical Education Credit toward the state requirements.

8 a.m. *Registration and Coffee*

9 a.m. Welcome: Edward M. Fugate, MD, Muskegon, Planning Committee chairman

9:15 a.m. **"Medical Screening Program for Athletes — New Concept Using Doctors, Trainers, and Coaches"**
Douglas McKeag, MD, Department of Family Practice and Sport Medicine, Michigan State University, East Lansing

9:45 a.m. **"Strength Testing as Part of the Physical Screening Examination"**
Clint Thompson, MS, Certified Athletic Trainer, head, Department of Athlete Training and Rehabilitation, Michigan State University, East Lansing

10:15 a.m. *Coffee Break*

10:30 a.m. **"Drugs, Society, and the Athlete"**
Donald L. Cooper, MD, director, Oklahoma State University Student Hospital and Clinic, OSU Team Physician, Stillwater, Okla.

11:00 a.m. **"Injury Prevention in Athletes"**
David C. Bachman, MD, director, Northwestern University Medical School Center for Sports Medicine, Chicago

11:30 a.m. **"Difference in Treatment Rules in High School and College"**
Allen Bush, Director of Athletics, Michigan High School Athletic Association, Inc., East Lansing

12:00 noon *Luncheon*

12:45 p.m. **"Competitive Athletics: A Plus in Higher Education"**
Joseph Kearney, Athletic Director, Michigan State University, East Lansing

1:15 p.m. **"Non-orthopedic Problems in Sports Medicine"**
David Hough, MD, Department of Family Practice and Sports Medicine, Michigan State University, East Lansing

1:45 p.m. **"On the Field Evaluation of the Injured Athlete"**
Donald L. Cooper, MD, director, Oklahoma State University Student Hospital and Clinic, OSU Team Physician, Stillwater, Okla.

2:15 p.m. **"Non-operative Treatment of Ankle Injuries"**
Ken Kopke, Certified Athletic Trainer, coordinator, Sports Medicine Service, Central Michigan University, Mt. Pleasant

2:45 p.m. **"Treatment and Diagnosis of Soft Tissue Injuries"**
Richard Hoover, head, Education Department, Northwestern University Medical School Center for Sports Medicine, Chicago

3:15 p.m. **"Trauma to the Foot: Diagnosis, Treatment, and Rehabilitation"**
David C. Bachman, MD, director, Northwestern University Medical School Center for Sports Medicine, Chicago

3:45 p.m. **"Conservative Treatment of Collateral Ligament Injuries to the Knee"**
Gerald A. O'Connor, MD, head, Department of Sports Medicine, University of Michigan, Team Physician, Ann Arbor

4:15 p.m. *Conference Ends*

REGISTRATION FORM

Please return to: MSMS Conference on Medical Aspects of Organized Athletics
PO Box 950, East Lansing, MI 48823 Phone: 517/337-1351

Name ____________________

Address ____________________

City ____________________ **State** __________ **Zip** ________

Check one: (Registration fee includes lunch)

☐ **Physician ($15)** ☐ **Trainer ($10)** ☐ **Coach ($10)** ☐ **Other ($10)**

Please make checks payable to Michigan State Medical Society

CAPSULES

MSMS is sponsoring a medical reporting seminar for journalism students April 19 at Michigan State University. The seminar, to be held at the MSU Union Building, will feature a panel of physicians and journalists discussing current medical issues, suggestions for good sources of medical information, and a simulated press conference. This is a project of the MSMS Committee for Public Service, Thomas C. Payne, MD, Lansing, chairman.

* * *

Americans think the two most effective means of improving people's health is to (1) provide comprehensive health insurance coverage for all Americans and (2) stop the rise of medical care costs. In a survey conducted by the Health Insurance Institute, Americans were asked their opinions of 10 ways to improve people's health. Very few respondents thought there was a need for more doctors or hospitals, while two percent cited each of these possibilities. Provision of comprehensive health insurance was the most frequent response, offered by 28 percent, while 23 percent said putting a lid on rising health costs.

Public Health code set aside for appropriations bills

The proposed new state public health code is being put on the back burner as the legislature turns its attention to appropriations bills. The proposed public health code won't be considered by the lawmakers for at least six weeks, it is reported, as priorities are shifted in an attempt to clear all appropriations bills by adjournment in early June. Among the appropriations bills will be those to fund Medicaid. The MSMS Medicaid Liaison Committee will be working diligently to assure that Medicaid payments are maintained at the current Medicare levels. That parity was won in summer, 1977 through MSMS-supported legislation.

State asking $100 million re: PBB

The Attorney General is suing Michigan Farm Bureau and Michigan Chemical Corporation for over $100 million in damages as a result of their actions in mixing PBB into livestock feed. The suit also asks coverage of all additional expenses incurred by Michigan for research and other purposes to protect the public health, and for the court to appoint a specia master to audit all additional expenses of the state with regard to PBB contamination for the purpose of adding those expenses to the court's judgment.

AMA advising HEW on Medicaid MI

The AMA is urging HEW to withdraw its directive to make available to the media information about the physicians who received more than $100,000 from Medicaid in 1977. HEW proposes to send to every physician a letter showing the amount received from Medicare and to give the doctor 30 days to correct any errors. Then, HEW proposes to release the list April 30. The list last year had a 65 percent error rate, according to the AMA.

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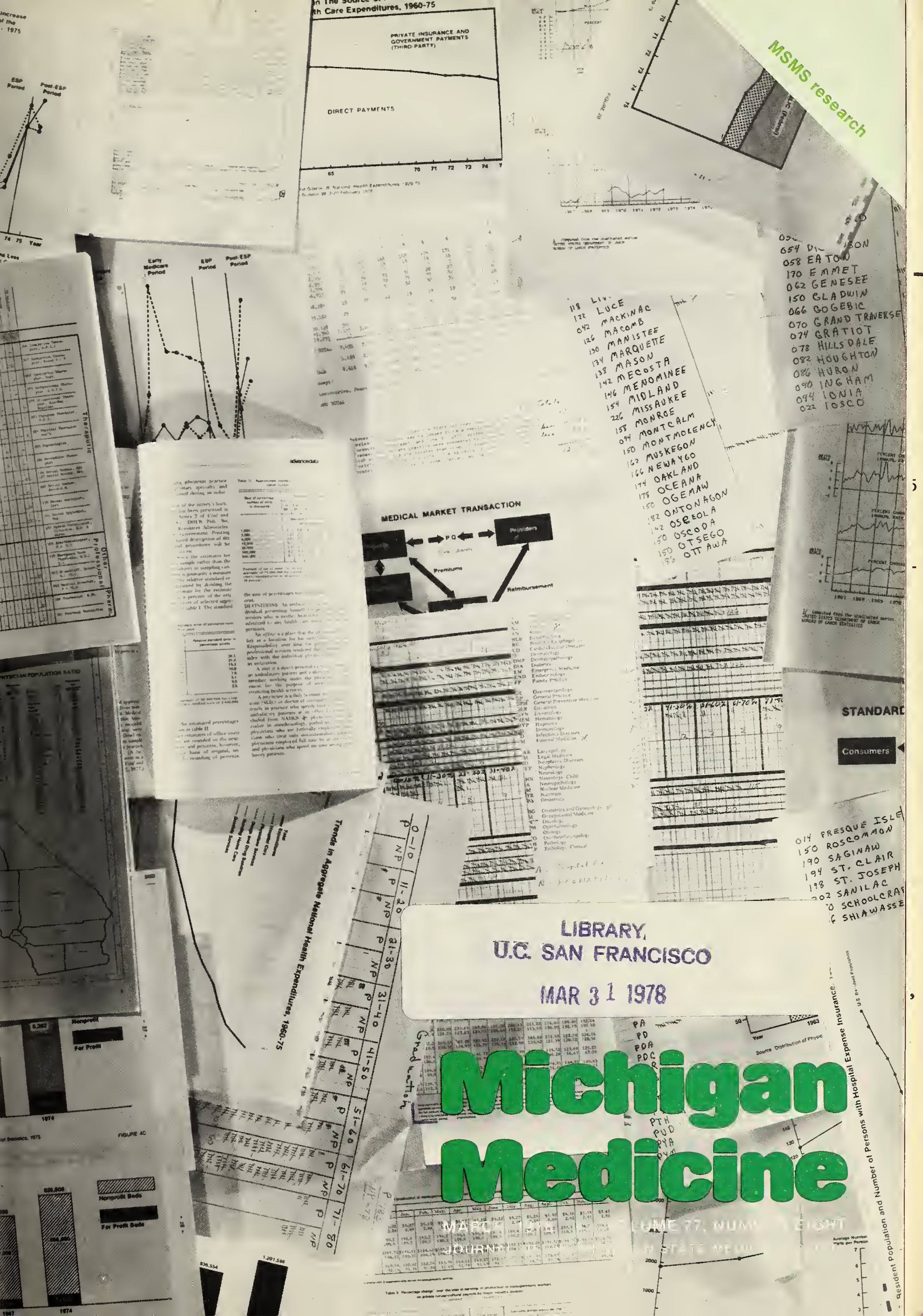
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Michigan Medicine

MARCH 1978 VOLUME 77, NUMBER EIGHT

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

CAPSULES

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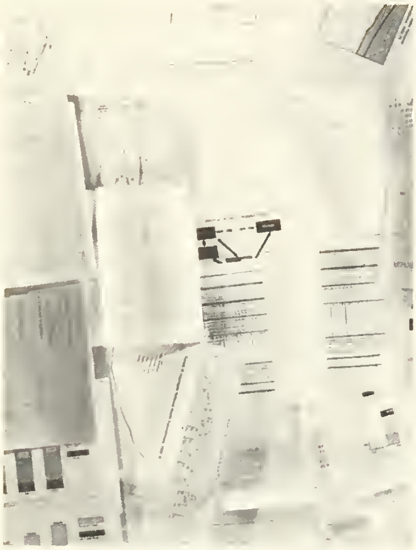
Contents

Michigan Medicine, **the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**



BILL MITCHAM

MSMS is gathering its own data as research activities expand to better serve Michigan physicians. See pages 125-128.

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MSMS expanding activities in socioeconomics of health care

By John Richards, Chief
MSMS Bureau of Economics

MSMS increasingly is being asked to participate in or respond to research projects investigating the socioeconomic aspects of health and health care in the U.S. The MSMS Council, recognizing Michigan physicians many times are affected by policy decisions based on these findings, directed the Bureau of Economics to reorganize in order to provide assistance to MSMS members in this area.

The priorities and projects undertaken by the bureau will be established by the Committee on Socioeconomics, chaired by John Bryan, MD, Royal Oak. The committee will recommend to The Council projects in which MSMS should take an active part, or to which it should lend assistance, and will recommend the form of assistance to be offered. The committee also will screen requests for access to MSMS information.

The bureau now will focus its activities on (1) monitoring research activities or data-gathering activities of other groups. This will include, when appropriate, liaison and participation with groups seeking information, analysis of the data produced, and interpretation of results; (2) surveys of the MSMS membership in order to better understand the most important interests and issues; and (3) educational programs on practice management and the financial aspects of medical practice.

To keep abreast of significant research projects and to follow the progress of projects, the bureau maintains liaison with a number of groups.

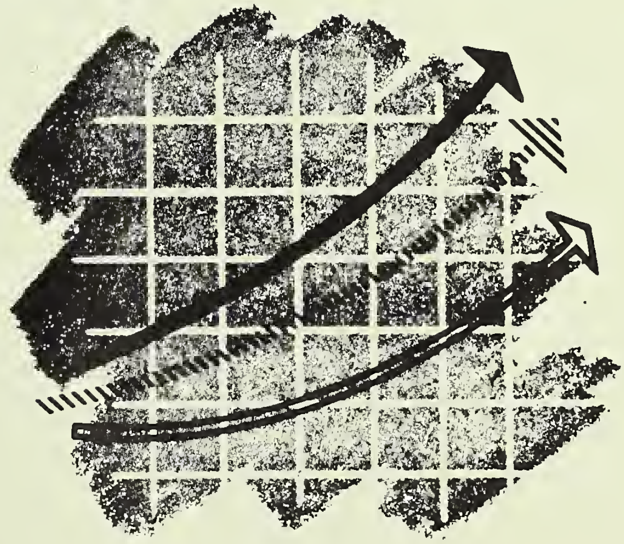
For instance MSMS has accepted an invitation to serve on an advisory committee to the Michigan Health Data Corporation. This corporation was formed by the state universities, government agencies, third party carriers, and the Michigan Hospital Association. Its initial task will be to collect data for the University of Michigan School of Public Health's Bureau of Hospital Administration to indicate the "performance" of Michigan hospitals. The MSMS Council soon will decide whether MSMS should become a member of the corporation board.

The bureau also has been active in the area of health manpower. Cooperating with the Michigan Medical Schools Council of Deans, the bureau is trying to determine the number of Michigan medical graduates who practice in the state. The Council of Deans soon will be presenting data indicating Michigan does a good job of retaining its medical school graduates.

Another bureau project is the professional liability survey. In 1976 the Michigan legislature passed the Malpractice Claims Reporting Bill, requiring each claim filed for medical malpractice to be reported in detail to the state insurance bureau. When the claim is closed, a second report must be made as to its eventual disposition. This information is used by the state in a number of ways, but MSMS felt analysis of this data would be most valuable in preventing claims. As a result, the bureau periodically undertakes comprehensive evaluation of the claims, as part of a cumulative study. MSMS hopes to be useful in making recommendations for remedial action either by the physician population or the legislature.

The bureau also reviews and interprets data from the consumer price indices, reports of government agencies, special study commissions, HEW research projects, university studies, and other sources of primary data. The bureau's job is to analyze the information published by these groups, understand apparent inconsistencies, and put the data in a form useful to MSMS committees charged with making policy recommendations.

The goals of the bureau's monitoring and liaison activities are to know what types of research projects are being undertaken by various groups in the area of health care, to try to place the results of these activities in the proper perspective, and to ensure the physician's perspective will be taken into consideration. ◥



MSMS' own data will aid MDs in attacking hearsay claims

By C. R. Shelton
***Special to* Michigan Medicine**

"Doctor, do you really know to what extent *you* are responsible for the cost of medical care, and what changes you might make to help improve the quality of care that Michigan residents receive?"

Those questions were posed recently by John B. Bryan, MD, Royal Oak internist, during an interview for *Michigan Medicine*.

Doctor Bryan, past president of the Oakland County Medical Society, and currently chairman of the Advisory Committee to the MSMS Bureau of Economics said, "Certainly, most of us physicians don't have 'hard' facts on those or most other socioeconomic questions at our fingertips even though we could use them frequently.

"But the MSMS Bureau of Economics has conducted, or is in process of designing, surveys which can make such important information available to each member of the society.

"We have developed quite an expertise in designing our surveys, and we are gratified by the returns we have had from MSMS members. Returns have been as high as 76 percent on some surveys.

"So far, we have used written surveys only, but we will utilize other methods to collect data in the future. That probably will come about when we begin to gather information from hospitals."

Doctor Bryan

Information important

Doctor Bryan added the up-to-date information obtained by the bureau can be extremely important to MSMS' House of Delegates, and to The Council, in setting the society's positions on key issues.

"But it also is vitally important to individual physicians, in these days when practically any self-claimed protector of the consumer can gain headlines by attacking those of us involved in the delivery of medical care.

"Before the bureau was established, there just was no way for us to challenge hearsay claims made against us because we had no valid data on which we could base a stance."

The bureau operates under a charge from the MSMS House of Delegates. Its major role is to gather information to provde the society with proven data on the socioeconomics of medical care. Its philosophy is to make that information the most irrefutable that can be obtained by scientific research methods.

MSMS surveys will provide valuable facts

The MSMS Bureau of Economics plans to use member surveys extensively. Members already may have received an MSMS postcard survey asking about participation with Blue Cross/Blue Shield of Michigan. (See related article.) Surveying is an increasingly popular way for organizations such as MSMS to determine the feelings of members.

The random sample survey is quick, relatively low-cost and is selected to insure the best "fit" to the population being sampled. A sample of the MSMS membership is biased in favor of urban areas and certain counties with large populations, to reflect the make-up of the MSMS membership.

For membership profiles, MSMS will develop a mailing list representing the demographic, social, and professional characteristics of the MSMS membership. Surveys and questionnaires will then be sent to those individuals. This type of survey generally is used to gather more detailed information. This method takes more time to compile and is used for gathering basic information and facts, rather than for sampling opinions on current issues.

The results of the surveys will at all times be held confidential, and the results reported only as aggregate figures.

The information compiled from the surveys will be extremely valuable. It will give the leadership of the society a better understanding of how physicians feel about current issues. The data also will be put to use to assist The Council and House of Delegates to establish priorities. By taking the time to fill out the survey, members will be doing the society a valuable service. This information is needed by MSMS leaders to make the society as responsive to physicians' needs as possible.

The results of the bureau's efforts are published in *Michigan Medicine*, so that members have ready, and lasting, access to the findings.

The Committee on Socioeconomics, which meets quarterly, acts as advisor and coordinator for the activites of the bureau. It initiates research into areas it feels will benefit the MSMS membership, and approves proposed research projects in which the society has been requested to be a participant. Educational seminars regarding practice management and the financial aspects of medical practice are a part of the bureau's responsibility. The committee, through the bureau staff, also maintains liaison with other agencies and organizations carrying on similar activities and provides background information to those agencies with legitimate research goals.

Current members of the committee, in addition to Doctor Bryan, are: Donald D. Finlayson, MD, Sault Ste. Marie; Louis E. Heideman, MD, Birmingham; George A. Kling, MD, Detroit; Robert M. Leitch, MD, Battle Creek; and Robert E. Rice, MD, Greenville.

"The bureau basically is a reporting wing of the society," Doctor Bryan continued. "By that I mean we do not make recommendations, we report facts."

Containing costs the goal

The bureau's main interest now is to see if it can help contain the cost of medical care as the physician may influence it, says Doctor Bryan.

"We are very interested in gaining and distributing factual information about that subject, as well as about fees, how physicians can make their delivery of medical care more effective without increasing costs, geographic locations of physicians, and the use of allied health professionals. We also are interested in what the cost of doing business is to physicians, and what a physician's economic return is, or is likely to be, on his or her investments, i.e., medical education, offices, personnel, and other necessities.

"But our research activities are not solely dedicated to data-gathering within the confines of the MSMS membership, because we monitor and sometimes participate in the activites of other state medical societies and specialty groups. Of course, we report on the information we obtain from those groups.

"That type of data can be invaluable to Michigan physicians because by describing what is working, or not working, in other localities and/or associations. We may be able to increase our effectiveness, or avoid difficulties without learning how to do so by trial and error."

Why does a busy physician, with very little free time, devote so much of that time to chairing a committee on socioeconomic research?

"I believe that the information the bureau can provide is so important to Michigan physicians and to the MSMS that I am willing to give as much effort and time to it as I can," Doctor Bryan answered.

Nearly one-third of Michigan physicians surveyed report they at one time participated with Blue Cross/Blue Shield of Michigan, but are not now. Details are on pages 131-132.

MSMS helps physicians use offices efficiently

ANTHONY GIANNANTONIO
MORLEY
KRAUSE

A recent MSMS practice management workshop for beginning Michigan physicians earned the close attention of the audience.

One of the most important ways for physicians to help reduce costs in health care is to use the resources in their offices efficiently. The MSMS Bureau of Economics has two methods for helping physicians. The bureau keeps a close watch on what is happening in the general economy in order to provide physicians with information they need to make decisions regarding the financial management of their practices. Secondly, it offers seminars and courses on practice management techniques to help physicians organize their practices to make the best use of their time, personnel, and office.

The general state of the economy can have a great effect on a physician and his practice. Third party carriers, collection, and a physician's personal money management all are subject to variations in the economy and to the cycle these variations can take. The bureau studies and analyzes these variations and keeps abreast of the different aspects of the business side of medical practice. Third party carriers are especially sensitive to trends in the economy. It is therefore much easier to understand the carrier's reactions to situations when we understand the basic underlying economic imperatives they must consider when they establish certain policies. Additionally, the bureau will advise physicians on how long-range economic policy will affect their decisions.

Mr. Richards

Another feature of the bureau is the presentation of seminars on practice management. MSMS and the AMA annually offer a two-day seminar to senior residents on "Establishing Yourself in Medical Practice." These seminars, taught by professional management personnel, cover topics a physician needs to start a practice. The residents are exposed to a number of topics in these seminars which are not covered in their medical education. They receive in-depth instruction on personnel policies, facilities, patient flow, record-keeping, practice setting, and the legal aspects of medical practice. In addition, each physician attending the workshops is supplied with a workbook, which can act as the office manual when the practice is established. The response to these seminars has been tremendous. Many times residents who have attended them continue to seek advice and information from the bureau as their practices grow.

The second set of seminars offered by MSMS is for established physicians, to help them in the financial control of their practices. These half-day seminars are held annually in various parts of the state. Taught by personnel actively engaged in professional management situations, the workshops cover such topics as billing systems, finances and bookkeeping, collections, and insurance billing. Many phsicians return to these seminars to review techniques and to seek further help.

Bureau of Economics staff also can help individual physicians with specific problems in their practice management. Many times a physician is reluctant to view his practice as a business, and it is true that providing health care is the priority item to a physician. But many times problems in the office are the greatest impediment to this goal. A smooth-running office and financial system can provide the physician with many additional hours to concentrate on serving his patients. MSMS offers many services in this area and will make every effort to help its members in accomplishing these goals.

—JR

Learned professions must correct incorrect ideas

The learned professions are under attack. We frequently hear comments such as the following:

Theology

"Monies collected are not dispensed and are over-subscribed for future needs."

"Pseudo-theologians line their pockets with contributions by the faithful."

"Persons need to seek other than traditional religions."

Law

"Incompetent lawyers attempt to provide services they cannot perform much to the expense of their clients."

"There is no justice in the courtroom, only settlement of a complaint to the benefit of the legal system, courts and respective lawyers."

"Lawyers, paper shufflers for money, et al, leave personal morality at home."

"The tort system and judicial process need massive overhaul."

Medicine

"Costs are too high."

The public, according to recent national surveys, has the high cost of medical care on their minds. They rank the physician number one in ethics, they insist upon voluntary medical care and freedom to select their physician. Eighty percent of the public is satisfied with their own health care, and seventy-one percent have confidence in the AMA.

Yet, though seventy percent of those surveyed have their own hospital and doctors' costs covered, they worry the cost will rise too fast for them some day.

Fear is the problem. People insist upon quality, and full medical care, but are fearful of costs. Yet they are not willing to trade off quality to get less expensive care.

Doctors in the same surveys report they feel they are independent, confident of their skills as technicians, are not too concerned about excess paperwork, are insistent that they should set medical standards, and feel they are losing control of their profession.

So, the learned professions must concern themselves with the public attitudes and with what's being said.

Because if we continue to let these thoughts prevail we will destroy the makeup of our society. If we don't refute those ideas which are refutable, and don't correct those ideas whose time for correction has come, the demise of the professions is imminent. ◥

Vernon V. Bass, MD
MSMS president

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MSMS' newest survey discloses members' Blues activities

By John Richards, Chief
MSMS Bureau of Economics

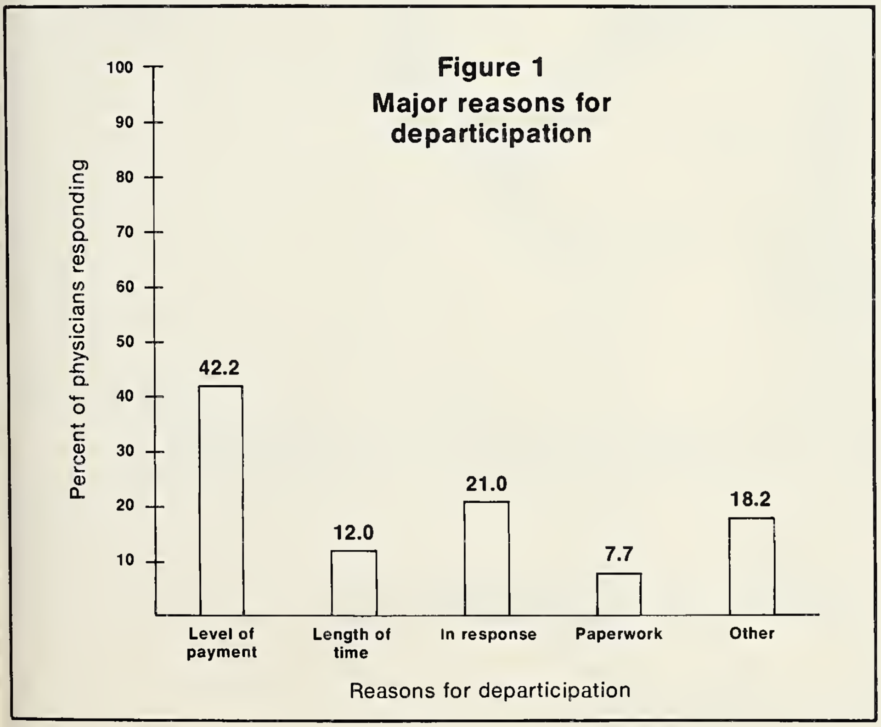
Over 31 percent of MSMS members responding to a survey just completed by the MSMS Bureau of Economics say they participated with Blue Cross/Blue Shield of Michigan at some time in their careers but are not now.

This is perhaps the most significant finding of the survey, which was initiated by the Bureau to gather its own data in light of the recent reimbursement changes made by the Blues.

The survey was mailed to a random sample of 1,200 MSMS members in mid-January. Within two weeks, nearly 50 percent of the postcard surveys had been completed and returned. The number returned represents 6.4 percent of the total MSMS membership, or 7.4 percent of the members in active practice.

In response to the question about participating with BCBSM, 73.5 percent answering said they had, while 26.5 percent said they had never. Only 41.8 percent indicated they presently were par doctors, with 58.2 percent of the sample indicating non-par status at the present. This means 31.8 percent had resigned from the Blues program at some time in their careers.

The survey asked five questions which could be answered either by multiple choice or by a simple percentage figure: (1) Have you ever been a formally participating physician with BCBSM (have had a formally signed agreement to receive payment directly)? (2) Are you presently formally participating with BCBSM? (3) If you have discontinued participating with BCBSM, what was your major reason? (The choices were level of payment, length of time to receive payment, responding to the MSMS House of Delegates recommendation, paper work, or other.) (4) If you are not now a formally participating physician, approximately what percentage of your claims do you send in on a per-case basis? (5) If you are presently formally participating, what do you feel are the major advantages in this arrangement? (The choices were regular payments, level of payments, simplifies office procedures, no out-of-pocket expenses for patients, and other.)



The answer to the third question had to be reinterpreted as it became clear most physicians thought the survey asked why they were dissatisfied with BCBSM rather than why they had resigned from formal participation. Over 42 percent were dissatisfied with the level of payment, while the next highest category was in response to the MSMS House of Delegates recommendation (21.0 percent). "Other" was the third most commonly marked choice with 18.2 percent, followed by length of time to receive payment with 12.0 percent and paper work with 7.7 percent.

More than half (52.7 percent) of the physicians indicating a non-par status submitted less than 10 percent of their claims on a per-case or pay doctor basis. The next highest category was 12.2 percent indicating 91 to 100 percent of their claims were sent in on this basis. The remaining 35.1 percent of the responses was more or less evenly distributed between the 11th and 90th percentiles.

Regularity of payment was selected by 30.4 percent of the respondents as the major advantage of formal participation, with 26.3 percent favoring no out-of-pocket expenses for the patient, and 23.4 percent selecting simplification of office procedures as the overriding reason to participate. The "other" category was indicated by 12.4 percent, while 7.6 percent chose the level of payment as the major advantage.

Other conclusions

The above information was drawn directly from the questionnaire responses, but a number of other interesting pieces of information were compiled from the survey. It was possible to determine the level of participation of the respondents by

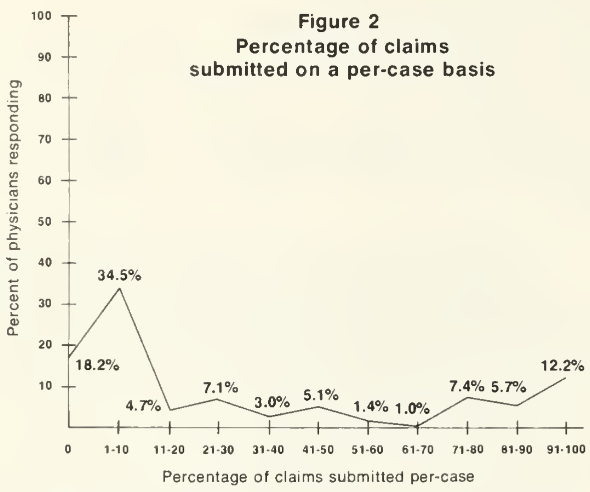


Figure 2
Percentage of claims submitted on a per-case basis

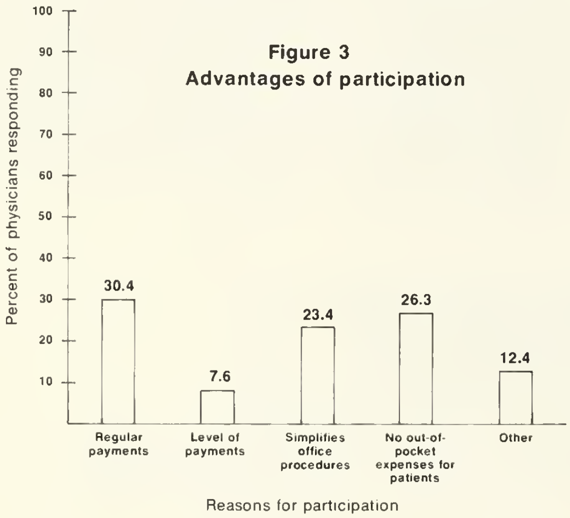


Figure 3
Advantages of participation

TABLE 1

County or Region	Percent of Physician Participation	Percent of Physician Non-participation
Muskegon County	8.3	91.7
Upper Peninsula	18.8	81.2
Ingham County	25.9	74.1
Jackson County	30.0	70.0
Southern Lower Peninsula (Less listed counties)	30.4	69.6
Genesee County	32.0	68.0
Northern Lower Peninsula	32.7	67.3
Kalamazoo County	36.0	64.0
Kent County	42.5	57.5
Oakland County	46.3	53.7
Wayne County	51.7	48.3
Saginaw County	56.2	43.8
Washtenaw County	57.1	42.9
Macomb County	61.5	38.5

county, specialty, and year of graduation from medical school by using the information stored in the MSMS computer. This information is valuable to supplement and enhance the data drawn directly from the postcards.

Those graduated from medical school between 1931 and 1940 indicated the highest level of participation with BCBSM in the survey, with 52 percent. 1961-1970 graduates indicated a 45 percent participation level, while the 1941-1950 group indicated 44.6 percent. The lowest level of participation was indicated in the 1951-60 graduation category with only 34 percent participation (66 percent non-par). This was the greatest difference indicated between participation and non-participation within a category.

The AMA specialty designations were combined into six major groups. These groupings were arbitrary, and reflect the data needs of the society for the current dispute with BCBSM. The six groups are primary care, surgical specialties, pathology, medical specialties, radiology, and psychiatry. Of these groups, psychiatry indicated the highest level of non-participation with 73.0 percent (27.0 percent par), followed by the surgical specialties with 65.2 percent (34.0 percent par), primary care with 56.9 percent (43.1 percent par), pathology with 53.9 percent (46.1 percent par), the medical specialties with 52.8 percent (47.2 percent par), and radiology with 43.6 percent non-par (56.2 percent par).

Interestingly, the county with the highest percentage of BCBSM subscribers, Genesee, displayed one of the lowest percentages of physician participation. This is particularly significant because Genesee is one of the highly urbanized areas where the Blues have concentrated their efforts. The results of the geographic distribution are shown in Table 1.

It is apparent a large amount of data can be compiled using a relatively simple survey device. The number of responses received was sufficient to draw conclusions with a high degree of confidence. The bureau hopes this data will help to establish policy in line with the major concerns of the MSMS membership.

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INDICATION: Contraception [ ]

CONTRAINDICATIONS: Oral contraceptives (OC's) should not be used in women with any of the following conditions

1. Thrombophlebitis, thromboembolic disorders or conditions which predispose to these disorders 2 A past history of deep vein thrombophlebitis or thromboembolic disorders 3 Cerebral vascular or coronary artery disease. 4 Known or suspected carcinoma of the breast 5 Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding 7 Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS:

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic These studies estimate that users of oral contraceptives are 4 to 11 times more likely to develop these diseases without evident cause than are nonusers. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4 to 9 5 times greater in users than in nonusers [ ]

An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported, confirming a previously suspected association These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not Oral contraceptives, however, were found to be a clear additional risk factor The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group [ ]

In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved This finding has been confirmed in the United States Cases of thromboembolic disease have been reported in women using progestin-only oral contraceptives, and they should not be presumed to be free of excess risk

The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age Oral contraceptives are, however, an independent risk factor for these events [ ]

The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception The estimates of risk of death for each method include the combined risk of the contraceptive method (e g , thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure This latter risk varies with the effectiveness of the contraceptive method [ ] The study concluded that the mortality associated with all methods of birth control is low compared to the risk of childbirth, with the exception of oral contraceptives in women over 40, and that the lowest mortality is associated with the condom or diaphragm backed up by early abortion

The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors The use of oral contraceptives in women in this age group is not recommended

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e g , thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis) Should any of these occur or be suspected, the drug should be discontinued immediately

A four- to six-fold increased risk of post-surgery thromboembolic complications has been reported in oral contraceptive users If feasible, oral contraceptives should be discontinued at least four weeks before surgery [ ]

2. OCULAR LESIONS There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision, sudden onset of proptosis or diplopia; papilledema, or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures.

3 CARCINOMA Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. [ ]

In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. [ ] One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in subgroups of oral contraceptive users with documented benign breast disease A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented

In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception

4 HEPATIC ADENOMA. Benign hepatic adenomas appear to be associated with the use of oral contraceptives Although benign, and rare, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage This has been reported in short-term as well as long-term users of oral contraceptives, although one study relates risk with duration of use of the contraceptive While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives [ ]

5. USE IN PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes

Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion) Some of these exposures were very short and involved only a few days of treatment The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births

In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestins are effective for these uses.

There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown.

Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive Many clinicians recommend 3 months

The administration of progestin-only or progestin-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6 GALLBLADDER DISEASE Studies report a doubling of the risk of surgically confirmed gallbladder disease in users of oral contraceptives or estrogen for 2 or more years.

7 CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives

An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives

8 ELEVATED BLOOD PRESSURE An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives.

9 HEADACHE The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause

10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. [ ] Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease

Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods.

11. ECTOPIC PREGNANCY Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. However, in oral contraceptive failures, the ratio of ectopic to intrauterine pregnancies is higher than in women who are not receiving oral contraceptives, since the drugs are more effective in preventing intrauterine than ectopic pregnancies. [ ]

12 BREAST FEEDING Oral contraceptives given in the postpartum period interfere with lactation. There may be a decrease in the quantity and quality of the breast milk Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs [ ] If feasible, the use of oral contraceptives should be deferred until the infant has been weaned

PRECAUTIONS: General 1 A complete medical and family history should be taken prior to the initiation of oral contraceptives The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests As a general rule, oral contraceptives should not be prescribed for longer than 1 year without another physical examination being performed 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size 3 Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree Patients becoming significantly depressed while taking oral contraceptives should stop the medication 4 Oral contraceptives may cause some degree of fluid retention They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, or cardiac or renal insufficiency 5 Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients 7 Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency 8 Serum folate levels may be depressed by oral contraceptive therapy Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted 10 Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives:

a Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3, increased norepinephrine-induced platelet aggregability

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered

d Decreased pregnanediol excretion.

e Reduced response to metyrapone test

INFORMATION FOR THE PATIENT (See Patient Package Insert)

DRUG INTERACTIONS: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with rifampin A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. [ ]

ADVERSE REACTIONS: An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS)

Thrombophlebitis, pulmonary embolism; coronary thrombosis, cerebral thrombosis, cerebral hemorrhage, hypertension; gallbladder disease, congenital anomalies

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed

Mesenteric thrombosis, benign hepatomas, neuro-ocular lesions, e g , retinal thrombosis and optic neuritis

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related

Nausea, usually the most common adverse experience, vomiting reaction, occurring in approximately 10% or less of patients during the first cycle Other reactions, as a general rule, are seen much less frequently or only occasionally, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting; change in menstrual flow, dysmenorrhea, amenorrhea during and after treatment, temporary infertility after discontinuance of treatment, edema, chloasma or melasma which may persist, breast changes: tenderness, enlargement and secretion, change in weight (increase or decrease), change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice, migraine, increase in size of uterine leiomyomata, rash (allergic); mental depression; reduced tolerance to carbohydrates, vaginal candidiasis

The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted

Premenstrual-like syndrome, intolerance to contact lenses, change in corneal curvature (steepening), cataracts, changes in libido; chorea, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, hirsutism; loss of scalp hair, erythema multiforme; erythema nodosum, hemorrhagic eruption, vaginitis; porphyria, impaired renal function.

ACUTE OVERDOSE: Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children Overdosage may cause nausea, and withdrawal bleeding may occur in females [ ]

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Meetings

(See also listing of Category I programs on page 148.)

March 24-31 — Michigan Doctors Study Club, Study/Ski Seminar, Snowmass, contact: Thomas R. Berglund, MD, c/o M. Guerin Tours, Inc., P.O. Box 868, Port Huron, 48060, 313/987-7370.

April 13 — "The Physician's Family," presented by St. John Hospital, Dept. of Health Education in Cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, ext. 321.

April 13 — Medical Aspects of Organized Athletics, Hilton Inn, Lansing, contact: Herb Auer, MSMS headquarters.

April 18 — Annual Legislative Day, MSMS Auxiliary, Olds Hotel, Lansing, contact: Mrs. Thomas Berglund, 618 Aquaview Drive, Kalamazoo, 49009.

April 21 — 28th Annual Meeting, State of Michigan Branch, American Association of Medical Assistants, Michigan Inn, Southfield, contact: Donna Fogal, AAMA branch president, 1306 Eighteenth St., Port Huron, 48060.

May 1-3 — MSMS Auxiliary Annual Convention, MSMS Auxiliary, Bay Valley Inn, Bay City, contact: Helen Schulte, MSMS headquarters.

May 5-7 — Annual MSMS House of Delegates meeting, Hyatt Regency Dearborn, contact: Dick Campau, MSMS headquarters.

June 15 — "Insurance Programs for Family Protection and Retirement Income," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

June 17-22 — AMA Annual Meeting, St. Louis.

July 10-14 — International Automotive-Medical Meeting, sponsored by the American Association for Automotive Medicine and the International Association for Accident and Traffic Medicine, at the University of Michigan, Ann Arbor, contact: AAMA Secretariat, P.O. Box 222, Morton Grove, IL, 60053.

Sept. 14 — "Legal Problems of Ending Medical Practice," presented by St. John Hospital, Dept. of Health Education in Cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Oct. 12 — "Pre and Post Retirement Medical Care for the Physician and His Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

***Nov. 7-9* — MSMS Annual Scientific Meeting, Detroit Plaza Hotel, contact: Herb Auer, MSMS headquarters.**

Nov. 23 — "How Do I Know When to Retire?" presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

JCAH recruiting physicians to serve as surveyors

The Joint Commission on Accreditation of Hospitals (JCAH) is currently recruiting physician surveyors for its Hospital Accreditation Program (HAP). Expansion within HAP has created a need for additional full- and part-time physician surveyors (field representatives) and applications are now being accepted. The next training/orientation class is scheduled for May 15, 1978, at JCAH headquarters in Chicago.

Surveyors must be currently licensed physicians with broadly based clinical backgrounds and experience in hospital medical staff practices. Consultative, communicative, and data collection skills are essential.

The surveyor position offers a base salary, a per diem allowance, and a benefits package that includes hospitalization insurance, group life insurance, and a tax-sheltered annuity plan. The position affords extensive travel opportunities, although survey teams usually work two or three months consecutively in one geographic area. Full-time surveyors work approximately eleven months per year and part-time surveyors work three months per tour of duty, subject to a minimum service of six months per year.

Physicians interested in applying for the surveyor positions, or those seeking additional information, should contact: Director of Personnel, Joint Commission on Accreditation of Hospitals, 875 N. Michigan Ave., Chicago, 60611, (312) 642-6061.

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of major areas of postsurgical infection due to susceptible indicated
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Ancef’ is present in bone, synovial fluid, skin and soft tissues (such as
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efore prescribing, see complete prescribing information in SK&F literature *PDR.* The following is a brief summary.

ndications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in
e treatment of the following serious infections due to susceptible
ganisms.

espiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae, lebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-
nsitive and penicillin-resistant), and group A beta-hemolytic
reptococci.

jectable benzathine penicillin is considered to be the drug of choice
the treatment and prevention of streptococcal infections, including
e prophylaxis of rheumatic fever.

ncef’ is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of ‘Ancef’ in the
bsequent prevention of rheumatic fever are not available at present.

enitourinary tract infections due to *Escherichia coli, Proteus mirabilis, lebsiella* species, and some strains of enterobacter and enterococci.

in and soft-tissue infections due to *S. aureus* (penicillin-sensitive and
nicillin-resistant) and group A beta-hemolytic streptococci and other
ains of streptococci.

ne and joint infections due to *S. aureus.*

pticemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and
nicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

docarditis due to *S. aureus* (penicillin-sensitive and penicillin-
sistant) and group A beta-hemolytic streptococci.

ppropriate culture and susceptibility studies should be performed to
termine susceptibility of the causative organism to ‘Ancef’.

ntraindications: ‘Ancef’ is contraindicated in patients with known
ergy to the cephalosporin group of antibiotics.

arnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED,
AREFUL INQUIRY SHOULD BE MADE CONCERNING PRE-
IOUS HYPERSENSITIVITY REACTIONS TO CEPHALO-
ORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES
IOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE
TIENTS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including ‘Ancef’, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of ‘Ancef’ may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When ‘Ancef’ is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: ‘Ancef’ may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: ‘Ancef’ (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in “Piggyback” Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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*Tissue penetration is regarded as essential to therapeutic efficacy; however, specific tissue levels have not been correlated with specific therapeutic results.

Views

We should study problems of child abuse reporting

By Douglas Sargent, MD
Detroit

I would like to report to Michigan physicians on the results of a recent survey of physicians' knowledge and practice in regards to child abuse reporting.

My colleagues and I believe it would be reasonable to examine the nature of problems in hospitals resulting from the requirements of child abuse reporting. At the outset it appears, as currently administered, the reporting law in Michigan places excessively heavy demands upon physicians' time and creates conflicts in doctors, who wish to save children from further injury but are dubious about the results of reporting.

We suggest this conflict results in the kind of irrational discrepancy between knowledge and practice which our survey has disclosed.

Burden on physicians

Under all of the existing reporting laws, the burden of casefinding and reporting falls most heavily upon physicians, especially those who work in hospital emergency rooms. When reporting laws are either poorly communicated or poorly understood by physicians and other hospital personnel, such laws are not likely to be effective. Thus, it is relevant to ask: How knowledgeable are doctors about child abuse reporting laws? In order to test knowledge in this area we surveyed all hospitals in Michigan (71) of over 250 beds. This provided a broad sampling of emergency room attitudes and practice in this State.

For several reasons we chose to ask questions about the use of photographs to record injuries: Photographic recording of injuries is of accepted medical value and is of special relevance to reporting of suspected abuse. Photographing of injuries is also a procedure important enough to have been specifically permitted without parental permission by the reporting law of Michigan and 10 other states. Yet we observed that hospitals do not uniformly employ this technique. This apparent inconsistency led us to believe that inquiry into hospital and physician behavior with respect to this one aspect of the reporting law would permit us to draw broader inferences about the current state of knowledge of and compliance with child abuse reporting law generally.

The reporting law

Michigan's child abuse reporting requirements are embodied in *Mich. Compiled Laws Ann.* §722.621-.634. Section 722.626, §§6(2) of that law states, in pertinent part:

"When a child suspected of being an abused or neglected child is seen by a physician, the physician shall make the necessary examinations, which may include physical examinations, x-rays, *photographs*, laboratory studies and other pertinent studies." (emphasis added)

This law has been given widespread publicity. Every hospital and almost every doctor in Michigan has seen a copy.

The survey

Despite the law's clearly-stated requirements (which in any case each respondent could easily have looked up) 9.6 percent of the respondents believe that the law in Michigan prevents the taking of photographs of a child's injuries without parental permission, 42 percent replied that they didn't know what the law stated, and 46 percent reported the law accurately. Thus a majority did *not* know the law. Even more curious, despite the widespread (although far from universal) knowledge that Michigan's law permits photos without parental permission, 35 percent of the respondents replied that their hospital regulations *prohibit* the taking of such photographs. Further, even those hospitals (46 percent) whose regulations permit such photographs tend not to implement this ability by providing readily accessible photographic equipment and technicians. Sixty-one percent replied that photo equipment was seldom or never available in or near the emergency room or pediatric ward.

In sum, accurate knowledge about one important aspect of Michigan's child abuse-reporting law is far from uniform, and neither hospital practice nor hospital regulations are consistent with the law. In view of the unusually high rate of return (73 percent) from the mailed questionnaire, which suggests an exemplary concern about the topic, it is of special interest to us that there is such a discrepancy between what Michigan's child abuse reporting law permits and what routine hospital practice actually is.

Discussion

We have assumed that the respondents' views accurately reflect hospi-

(Continued on page 140)

Doctor Sargent

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'No such thing as a free lunch'

(This article is republished here with the permission of the Free Enterprise Institute of the Amway Corporation, Grand Rapids. It is part of a series prepared for Amway and distributed throughout the country by the firm.)

In the first third of this century there existed a phenomenon with which most of us in the middle years or older are familiar. It was called the "free lunch" and it was obtained in the neighborhood saloon. Characteristically, the working man stopped in at the corner bar for a glass, mug, or pitcher of beer (depending on the size of his thirst) at the noon hour and to partake of the comestibles which were close at hand at the end of the bar. The assortment of hard-boiled eggs, pieces of herring, sliced meat, and other delicacies resembled nothing less than a delightful smorgasbord (according to a distant mental image). Although the beer was cheap by today's standards the lunch was cheaper — it was free! But was it really free?

If one gives a little thought to the situation, the combination of beer and free edibles has a strange resemblance to today's free school lunch program, the food stamp program, aid to unwed mothers, and very likely to the national health insurance programs of the future. Government representatives would like the voters to believe that the "free lunch" does exist and perhaps it does for some of the recipients of such aid. The following quotation concisely summarizes the fallacy of this fable, however:

"A natural part of human nature, it seems, is the unquenchable desire to get something for nothing. The fact that you don't pay for a lunch doesn't make it free. Somebody picks up the tab — and that's why government handouts are as spurious as free lunches. Government is never a source of material goods. Everything produced is produced by the people. Everything the government gives to people it first must take from them. The only money the government has to spend is that taxed or borrowed out of the people's earnings. When government decides to spend more than it gets in this way, the extra unearned money must be created out of thin air *via* the printing press. This devaluation is called inflation and it's the tab we all pick up when we allow government to sell us the myth of the 'free lunch.' "

In the old days, the price of the beer was enough to pay for the "free lunch," the sodium content of which was high enough to assure a grand thirst and a large consumption of the brew of the hops. Nevertheless, the barkeeper and the customer both ended up happy; the former made a nice profit and the latter had a full stomach and his "free lunch."

National health insurance never will be a "free lunch," in fact, some predict its recipients may find it unpalatable — both to the stomach and to the pocketbook. That it will be expensive one can have no doubt. That it will serve the needs of our patients one can have grave doubts.

If free health care is part of that "unquenchable desire to get something for nothing," American Medicine has a big job cut out for it. The "free lunch" of the saloon of the 20's and 30's is gone without a trace. The present govenment's concept of the "free (health care) lunch," if enacted, may stick in the craw of the American public forever.

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tal practice which, in turn, reflects the knowledge and practice of the emergency room physicians. While hospital policy and practice is generally set by the medical staff, complete accuracy might require individual staff physicians to be surveyed.* Nevertheless, the responses we obtained permit the inference that child abuse reporting causes hospitals many problems, and this fact, in turn, makes them reluctant to employ photographs as often as good medical practice requires and as freely as the law permits.

It is difficult from a legal point of view to account for hospital reluctance to take photographs when the statute is as clear as it is. Perhaps overcautious advice stemming from a fear of being sued or an overzealous though unjustified concern for patient privacy may have caused the hospital reluctance to take photographs. It would be interesting to explore how many hospitals actually set their policies in reliance on legal advice and how many do not. To the extent that many hospitals do not retain or regularly consult counsel, changes in state law may be implemented more slowly.

This study suggests that it would be reasonable to examine the nature of the problems created in hospitals by the requirements of child abuse reporting. While such an inquiry is beyond the scope of this initial survey, at the outset it appears that, as currently administered, the reporting law in Michigan (and probably in other states as well) places excessively heavy demands upon physicians' time — not so much to make the initial report as to testify at later hearings — and creates conflicts in doctors, who wish to save children from further injury but who are dubious about the results of reporting. We suggest that this conflict results in the kind of irrational discrepancy between knowledge and practice which our survey has disclosed.

**A larger, National survey is in preparation which will include these data.*

Doctor Sargent is clinical associate professor, WSU Medical School, Department of Psychiatry.

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(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formu lations should be administered only when indicated and should be discontinued immediately abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated pota sium tablets should be used only when adequat dietary supplementation is not practical.
Precautions: In response to a rise in the conce tration of body potassium, renal excretion of th ion is increased. With normal kidney function it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficien or daily dosage is not accurately known. Frequent checks of the clinical status of the patien and periodic ECG and/or serum potassium levels should be made. High serum concentra-

1954
1978
Time is the test of all things

of potassium ion may cause death through
ac depression, arrhythmias or arrest. This
should be used with caution in the presence
rdiac disease.
hypokalemic states, especially in patients
salt-free diet, hypochloremic alkalosis is a
bility that may require chloride as well as
sium supplementation. In these circum-
es, Kaon (potassium gluconate) should be
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s an excellent source of chloride ion (18.7
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are contraindicated. Other sources for
ide are sodium chloride and Diluted
ochloric Acid, U.S.P.
hould also be kept in mind that ammonium
cation exchange resin, sometimes used to
hyperkalemia, should not be administered
to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

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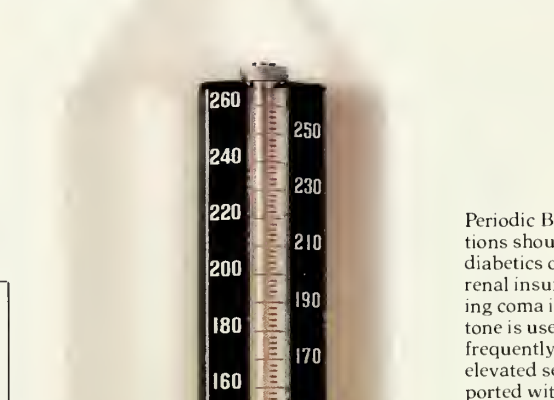

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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State should pay for SIDS autopsies

By Robert E. Fisher, MD
Battle Creek

Implementation of the Sudden Infant Death Law (PA 350) is unsatisfactory, and the law should be changed. Whether you are a medical examiner, prosector, teaching pathologist, physician, parent of an infant, or a paladin for Michigan children generally, your support will help get it changed.

Without "interfering with (his) duties and responsibilities," the medical examiner is directed by Section 52.205a of the Compiled Laws (Act No. 350, PA of 1974) to inform the parents (plural) of an infant dead of an unknown cause "that they may request an autopsy" (not authorize one) for which the state will pay. When he is dutiful, the examiner already will have told the parents compassionately that an autopsy to determine the cause of death has been ordered and that they will be told the findings. Their consent is neither required (pre-existing Sec 52.205 not .205a) nor should it be sought (Washtenaw Co. Med. Examiner, 1972). Act No. 350 would apply to the examiner when he has been culpably negligent.

Should the parents elect to not sign, the examiner has three wretched choices — show death "cause unknown, no autopsy;" invoke necromancy, or over-ride the parents' wishes and order autopsy at county expense as he should have done in the first place. If they do sign, the prosector is at some risk because he has no expressed authorization; if only one has signed, he works at great risk; and in either event to wait for signatures vitiates the results.

Only when all SIDs are autopsied without delay and the results collated (as by the Dept. of Public Health) can the best information from as many instances as possible be studied. The emphasis of CL 52.205a is on parental request; it should be on counseling. The state should assume autopsy costs without the bereaved parents having to sign a request for an autopsy, necessary after any unexplained death, so that the state instead of the county will pay for it. Shameful!

Representative Paul Rosenbaum agrees with me that Sec 52.205a (which as H.B. No. 5505 he cosponsored) would be the better for emendation but says his colleagues are not so convinced. To my knowledge, Rep. Hood is one of these.

Mr. Rosenbaum says he will be pleased to receive letters from protagonists who believe the state should pay for SID autopsies on presentation of the original copy of a "proper" report and a statement of "reasonable" fee but without the presently required parental request. Please write him (at PO Box 30014, Lansing, MI 48909) if you think the law should be changed.

Doctor Fisher is Medical Examiner, Calhoun County.

(Editor's note: As this issue was going to press, The Michigan House Standing Committee on Public Health reported HB 5616 out to the floor of the House. The bill had been stalled in the committee for four months. The bill at present deletes the requirement for parental request for autopsy as a prerequisite for payment for the autopsy by the state. Doctor Fisher therefore sees no need for further physician concern at this time, but urges watchfulness of the bills' progress.)

Doctor Fisher

New drug lag not indigenous to US: FDA head

The new head of the Food and Drug Administration calls for "a truce in the statistical battle between the FDA and its critics" in an article in the Jan. 30 *Journal of the American Medical Association.*

Doctor Donald Kennedy urges "a process familiar to all physicians: careful diagnosis and prescribing" in approaching the problem of time lags in approval of new drugs for use in the United States.

"If there is a drug lag, it is not a long-term condition indigenous to the United States; instead, certain nations are ahead in some drugs and behind in others," he says. Critics of the federal regulatory agency have charged that many drugs are available in other nations long before they are approved in the United States. The delay has been blamed on excessive regulation on the part of the FDA. Not so, says the FDA chief.

The United States had the second fewest new drug introductions of the six major drug development countries in 1976, Doctor Kennedy reports. The others are the United Kingdom, France, the Federal Republic of Germany, Italy and Japan.

Whether a drug is introduced first in the United States or in some other nation often is a business decision of the multinational pharmaceutical industry, Doctor Kennedy maintains.

Mrs. Lane

'It's rewarding to associate with such giving people'

(Editor's Note: This article is reprinted, with permission of author and editor, from the "Ingham Review," monthly newsletter of Ingham Medical Hospital, Lansing. Mrs. Lane is the recipient of an MSMS Presidential Citation, one of five Michigan reporters honored during 1977 for continuing outstanding journalistic efforts to explain health care and medically-related issues.)

By Millicent Lane
Lansing

Somebody asked me one day what it was about my job that I liked. It didn't take long to answer: the people I meet.

There is an old saying in the newspaper business, something about "but you meet the most interesting people."

It's true.

And it's especially true when the assignment is covering health and health-related stories.

But, more than interesting, the people in health care are special. They do special things. They deserve special mention.

Human nature being what it is, however, people are more apt to remember the negative things.

They recall long waits in a doctor's office. But how about the doctor who foregoes a couple of office hours to be by the side of a patient after an operation. Or the doctor who sits throughout the night by the bed of a critically ill child. Or the doctor who discusses with a teenager those things the teenager is afraid to talk over with parents.

People are apt to recall the nurse who got the blood pressure band too tight or didn't promptly answer the hospital call bell. But how about the nurse who, after her only child died, wouldn't let bitterness take over but gave a gift to a hospital for other sick children. Or the school nurse who buys shoes for needy children for school, and toys to make their Christmas less empty. Or the nurse who holds a child frightened by the antiseptic, bustling, businesslike atmosphere of a hospital.

There are so many others in health care who should be mentioned, not only in hospitals but in nursing homes, health departments, medical schools and other health environments.

There are the aides who give affectionate comfort to lonely elderly. The housekeeper who pauses in chores to fill a patient's needs for companionable conversation. The pharmacist who patiently explains medication instructions. The technologist who calms fears about the needle inserted in an arm to draw blood for tests.

And there are other specially-trained experts behind the scenes whose prompt work and round-the-clock duty so often goes unrecognized.

How about the public relations specialists working to bring the health care story to the public.

When a reporter, doing her job, happens to write about these people, do you know what happens! After the story appears, these people are apt to write or call with thanks. Or embrace you when they meet you.

And all I'm doing is writing what they say or do. It's my job. But it's more than that. It's a pleasure. It's genuinely rewarding to be associated in this way with such "giving" people. I'd like to say thank you, thank you very much.

Mrs. Lane is medical reporter for The State Journal, Lansing.

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*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Category I courses

Date: March 16-17, **Newer Concepts in Gastrointestinal Surgery. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $130. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 17, Workshop on Aging. Location: Traverse City Regional Psychiatric Hospital. **Sponsor:** Traverse City Regional Psychiatric Hospital, Department of Geriatrics. **For:** Gerontologists, internal medicine, family practice. **Cost:** $15. **Contact:** Charles W. Shipman, MD, 14735 Shipman Drive, Traverse City, 49684. **Approved for:** 6 hours of Category I Credit.

Date: March 22-23, Advances in Pediatrics. Location: Towsley Center for Continuing Medical Education. University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $120. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 29, Breast Cancer — 1978. Location: Hilton Inn, Lansing. **Sponsor:** E. W. Sparrow Hospital, Department of Family Practice, and Capital Chapter of MAFP. **Contact:** R. W. Pomeroy, MD, Director, Continuing Medical Education, E. W. Sparrow Hospital, Box 30480, 1215 E. Michigan Ave., Lansing, 48909. **Approved for:** 7 hours of Category I Credit.

Date: March 30-31, The Spine and Spinal Cord. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 31-April 1, Regional Drug Abuse Conference. Location: Water Tower Hyatt Hotel, Chicago. **Sponsor:** AMA. **For:** Physicians in Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin. **Cost:** $50 members, $100 nonmembers. **Contact:** E. M. Steindler, director, Department of Mental Health, Division of Scientific Activities, American Medical Association 535 N. Dearborn, Chicago, 60610. **Approved for** Hour for hour Category I Credit.

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Because of space limitations, it is not possible to list the many continuing courses and series sponsored by many hospitals and organizations in Michigan. Information about those possible programs may be obtained from the accredited sponsors.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo State Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City State Hospital Traverse City
V.A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: March 31-April 1, Advanced Cardiac Life Support Certification Course. Location: The Kellogg Center for Continuing Education, Michigan State University, East Lansing. **Sponsor:** Michigan Heart Association. **Co-sponsor:** Michigan State University College of Osteopathic Medicine and Ingham Medical Center. **For:** All specialties. **Cost:** $160 physicians; $100 EMTs. **Contact:** Ann Tsiminakis, Conference Coordinator, Continuing Education MSU, Kellogg Center, 517/353-7822. **Approved for:** 16 hours of Category I Credit.

Date: April 1, Aging: Intergenerational family therapy promoting the process of growth for the elderly. Location: Ramada Inn, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** 313/545-1144 or 313/662-2330. **Approved for:** 3 hours of Category I Credit.

Date: April 3-7, Occupational Skin Diseases. Location: Dearborn Inn, Dearborn. **Sponsor:** Wayne State University School of Medicine Dept. of Dermatology; American Academy of Dermatologists. **For:** All specialties. **Cost:** $300. **Contact:** Wayne State University Division of CME*** **Approved for:** 27 hours of Category I Credit.

Date: April 5, 12 and 19, Pulmonary Functions. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital. **Cost:** None. **Contact:** R. W. Pomeroy, MD., E. W. Sparrow Hospital*** **Approved for:** 3 hours of Category I Credit.

Date: April 6-7, Ophthalmology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education.* **Cost:** $140. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: April 11-13, EKG Diagnosis. Location: Towsley Center for CME, U-M Medical School, Ann Arbor. **Sponsor:** Dept. of Postgraduate Medicine and Health Professions Education. **Contact:** Dr. Floyd C. Pennington.* **Approved for:** 23½ hours of Category I Credit.

Date: April 12-13, Symposium on Child Development. Location: Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association. **Co-sponsor:** SMAHEC. **For:** Pediatricians, family practitioners, obstetricians. **Contact:** Valerie Lincoln, RN, Perinatal Coordinator, Bronson Hospital, 252 E. Lovell, Kalamazoo, 49007. **Approved for:** 11 hours of Category I Credit.

Date: April 13, Medical Aspects of Organized Athletics. Location: Hilton Inn, Lansing. **Sponsor:** Michigan State Medical Society. **For:** Team doctors, coaches, athletic trainers. **Contact:** Herb Auer, MSMS headquarters, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 13-15, Critical Care Symposium. Location: Wayne County Medical Society, 1010 Antietam, Detroit. **Sponsor:** Wayne State University School of Medicine, Dept. of Surgery; ACS — Michigan Committee on Trauma; and Mich. Chapter, American College of Chest Physicians. **For:** All specialties. **Cost:** $95 physicians; $45 physicians-in-training. **Contact:** Dr. Wilson, 313/224-0743. **Approved for:** 15 hours of Category I Credit.

MECO Program in seventh year

For the seventh successive year, MSMS is working with the American Medical Student Association in planning and developing the Medical Education Community Orientation program commonly known as AMSA-MECO.

The program exists to acquaint medical students who have completed their first year of training with practical clinical medicine in a community setting.

Under the program, MSMS enlists community hospitals from across Michigan which are willing to host one or more students and then invites medical students to apply for one of the available positions. Most programs run six to eight weeks during which the student(s) are rotated through the various hospital services to acquaint them with the type and range of services available in that hospital and community.

The hospital generally furnishes room and board for the student as well as a stipend of $75-$85 per week. In exchange the hospital has the opportunity to "sell" the student on the positive side of medicine in that community with the idea of encouraging the student to seriously consider practicing in that community when he/she finishes formal training.

One of the positive spinoffs for the physicians involved with these students is the chance to sharpen personal skills and refresh one's knowledge necessary to answer the questions raised by the inquisitive student. Some component societies have established programs whereby physicians match a student stipend with a hospital's stipend, thus enabling two students to have the opportunity to spend time in a given community.

Local hospitals have received applications to participate in this excellent program. MSMS members are actively working with your hospital administration in developing a meaningful program for these medical students. Please encourage your hospital board and staff to consider providing a position if it has not done so before. Or consider adding another position to the number you may have had before.

MSMS anticipates a record number of student applications for positions this summer due to changes in the Primary Care Preceptorship Program and we want to provide as many opportunities as possible.

Physicians with questions may contact Mert Scholten at MSMS, 120 W. Saginaw, East Lansing, 48823 (Tel. 517/337-1351).

Physicians' role in dental health focus of program

A national education program to enlist the aid of physicians in promoting the prevention of dental diseases will be carried out by Wayne State University (WSU) through a $282,955 grant from the W.K. Kellogg Foundation of Battle Creek.

Frederick Margolis, MD, Department of Pediatrics, WSU School of Medicine and a practicing pediatrician in Kalamazoo, will direct the program which focuses on the central role physicians can play in dental health.

"The physician's role is especially critical, since most children do not visit a dentist before age five," Doctor Margolis said, "Increasing the pediatrician's and family physician's knowledge of preventive oral health practices can be one of the most effective ways of reaching young people during their formulative years."

One of the approaches to be used through the project will be to provide physicians with educational material on the prescribed use of fluoride as a dental disease preventive.

Cooperating with the Wayne State University School of Medicine will be consulting faculty from the Schools of Dentistry, Medicine, and Public Health from the University of Michigan, as well as appropriate national health organizations.

CATEGORY I COURSES/*continued*

Date: April 14-15, The Wayne State University School of Medicine 11th Annual Cancer Symposium, "Cancer of the Colon and Rectum." Location: Gordon H. Scott Hall, 540 E. Canfield, Wayne State University, School of Medicine, Dept. of Oncology, Detroit 48201. **Sponsor:** Wayne State University. **Co-sponsor:** American Cancer Society, Michigan Division. **For:** Primary care physicians. **Cost:** $50. **Contact:** Wayne State University School of Medicine, Div. of CME,** **Approved for:** 8.5 hours of Category I Credit.

Date: April 17-21, Cardiac Tutorial Program. Location: Henry Ford Hospital, 2799 W. Grand Blvd., Detroit. **Sponsor:** Henry Ford Hospital. **For:** General Practitioners, Internists. **Cost:** $250. **Contact:** Sidney Goldstein, MD, Head, Division of Cardiovascular Medicine, Henry Ford Hospital, 2799 W. Grand Boulevard, Detroit, 48202 (313) 876-2727. **Approved for:** 40 hours of Category I Credit.

Date: April 17-21, Family Practice Review II. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-sponsor:** Michigan Academy of Family Physicians. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 37 hours of Category I Credit.

Date: April 25, Continuing Pathology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 6½ hours of Category I Credit.

Date: April 25, Infectious Diseases Symposium. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Hospital. **Contact:** Butterworth Hospital, Medical Education Office, 616/774-1835. **Approved for:** 8 hours of Category I Credit.

Date: April 26, Second Annual Pediatric Orthopedic Clinic Day. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** Detroit Orthopedic Clinic and Children's Hospital of Michigan. **Co-sponsor:** Wayne State University School of Medicine. **For:** All specialties. **Cost:** None. **Contact:** Richard LaMont, MD, Chief, Dept. of Orthopedic Surgery, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, 48201, 313/494-5581. **Approved for:** 6 hours of Category I Credit.

Date: April 28-29, Annual Meeting of Upper Peninsula Medical Society. Location: Terrace Motor Inn, Escanaba. **Sponsor:** Upper Peninsula Medical Society. **Co-sponsor:** Michigan State Medical Society. **For:** All specialties. **Contact:** A. Leslie Rose, MD, Doctor's Park, Escanaba, 49829, 906/786-4628. **Approved for:** 10 hours of Category I Credit.

Date: May 3, 10 and 17, The Family Practitioner and Psychiatry. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital. **Cost:** None. **Contact:** R. W. Pomeroy, MD, E. W. Sparrow Hospital.*** **Approved for:** 3 hours of Category I Credit.

Date: May 4-5, The High-Risk Infant. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $75. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 12 hours of Category I Credit.

Date: May 6, Alcoholism: Special problems and techniques in working with families in which alcohol is a problem. Location: Ramada Inn, Lansing. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** 313/545-1144 or 313/662-2330. **Approved for:** 3 hours of Category I Credit.

Date: May 9-10, InterQual's Concurrent Review Seminar. Location: Hilton Inn Lansing/7501 West Saginaw Highway/Lansing, 48917 (517) 627-3211. **Sponsor:** Endorsed by: Michigan Region VI PSRO, East Lansing; Western Michigan PSRO, Inc., Grand Rapids; Area VII PSRO, Ann Arbor. **For:** Medical Staff Members, UR Physicians, Administrators, Review Coordinators, Social Workers, All other hospital personnel. **Cost:** $130. **Contact:** Monica Eckart, Seminar Registrar, InterQual, 740 N. Rush St., Chicago, 60611. (Telephone registrations accepted, toll-free (800)621-6109; IL (312)751-2327.) **Approved for:** 8 hours of AMA Category I Credit and 10 hours American Medical Records Association.

Date: May 10, 18th Annual Spring Clinical Conference, "Practical Management of Cerebral Vascular Disease." Location: Kalamazoo Center, 100 West Michigan, Kalamazoo, Michigan 49006. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians. Internists, Neurosurgeons, General Practice, Emergency Medicine, Neurologists. **Cost:** $40. **Contact:** Charles L. Zeller, Jr., M.D., ℅ SMAHEC, 252 East Lovell, Kalamazoo, Michigan 49006. **Approved for:** 7 hours of Category I Credit.

Date: May 10, Cancer Update. Location: Gordon Scott Hall, WSU. **Sponsor:** WSU Department of Oncology. **Cost:** $25. **Contact:** Ms. Jeanette Radman, Department of Oncology, WSU School of Medicine, Scott Hall of Basic Medical Sciences, 540 E. Canfield Ave., Detroit, 48201. **Approved for:** 6 hours of Category I Credit.

Date: May 10-12, 21st Annual Clinic Days, "Orientation to Adolescent Care." Location: Children's Hospital of Michigan, Detroit. **Sponsor:** Department of Pediatrics and Department of Surgery, Children's Hospital of Michigan. **Co-sponsor:** Wayne State University School of Medicine. **For:** All specialties. **Cost:** $125. **Contact:** Community Relations, CHM, 3901 Beaubien Blvd., Detroit, MI 48201, 313/494-5373. **Approved for:** 18 hours of Category I Credit.

Date: May 12, 13, Conference for Physicians — "What Do You Say When Your Patient Asks About Nutrition?" Location: Lansing Hilton Inn. **Sponsors:** Dairy Council of Michigan; MSU Departments of Food Science and Human Nutrition, College of Human Medicine and College of Osteopathic Medicine. **For:** All interested physicians. **Cost:** $60 for physicians; $25 for residents; $10 for students. **Contact:** Dairy Council of Michigan, 313/875-3162. **Approved for:** 9 hours of Category I Credit.

Date: May 13, Michigan Society of Pathologists May Seminar. Location: Michigan State University, East Lansing. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: May 15-19, Head and Neck Oncology. Location: Towsley Center for Continuing Medical Education, University of Michigan, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Cost:** $500 for practicing physicians, $350 for physicians-in-training. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 42½ hours of Category I Credit.

Date: May 16, Continuing Pathology Conference. Location: The Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor, Michigan. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD.* **Approved for:** 6 hours of Category I Credit.

Date: May 17, "Diabetes Mellitus — 1978." Location: Hilton Inn, Lansing. **Sponsor:** Capital Chapter, Michigan Division of American Academy of Family Physicians. **Co-sponsor:** Michigan State Medical Society. **For:** Internal Medicine and Family Practice. **Cost:** $25. **Contact:** Richard L. Hatton, MD, 2321 Indian Hills Drive, Okemos, 48864. **Approved for:** 8 hours of Category I Credit.

Date: May 18-19, Third Annual Course in Forensic Pathology. Location: Radisson Cadillac Hotel, Detroit. **Sponsor:** Wayne State University School of Medicine and Wayne County Medical Examiner's Office. **For:** Pathologists. **Cost:** $80. **Contact:** Werner U. Spitz, MD, Chief Medical Examiner, 400 E. Lafayette Avenue, Detroit, 48226, 313/224-5648. **Approved for:** 12 hours of Category I Credit.

Date: May 22-26, Internal Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $250. **Contact:** Floyd C. Pennington PhD, U-M Office of Intramural Education.* **Approved for:** 33½ hours of Category I Credit.

Date: June 1-2, Preventive Health Care for the Elderly. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 11 hours of Category I Credit.

Date: June 3, Cultural Differences: The implication for treatment of cultural and ethnic differences among families and between family and therapist. Location: Ramada Inn, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** 313/545-1144 or 313/662-2330. **Approved for:** 3 hours of Category I Credit.

(Continued on page 152)

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*Office of Intramural Education, University of Michigan Medical Center, Dep't of PBM/HPE, Ann Arbor, 48109.

**WSU Division of CME, Room 1206, Scott Hall, 540 E. Canfield, Detroit, 48201 (313)577-1180.

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

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Deans Council developing medical-legal curriculum for MDs

The Michigan Medical School Council of Deans is cautiously optimistic as it awaits word from Washington on funds to develop a graduate medical-legal curriculum for physicians.

The medical-legal project also would be modified and taught to medical students, and is under review by the Health Care Financing Administration. The Deans Council is asking $350,000 to finance the project, a major effort of the continuing medical education units of the four Michigan medical schools.

The Deans Council, in its fifth year, is active in several areas. Director Ralph Lewis reports the Council expects to complete in March a checklist of issues to be considered when medical schools seek to affiliate with hospitals and other institutions for teaching programs. This checklist, unique in the country, will help medical schools consider all the issues involved in affiliations, including arrangements for medical students, nurses in training, and allied health professionals in training. The project has been field tested this winter.

The Deans Council has been working with the medical schools' Educational Affairs Committee, drawing up a single document for interchange agreements between the medical schools on clerkships and basic sciences.

The Deans Council continues to work in the area of physician manpower, to keep up-to-date information on medical school graduates, graduate training, location of physicians' practices, and specialty distribution around the state. The Council has met with the Michigan House of Representatives Republican Caucus Task Force on Health Manpower Resources, to help that group obtain information and data about medical schools and medical education.

The Deans Council meets regularly with the Michigan Association for Medical Education, the Statewide House Officers Training System and the State Health Coordinating Council. It works with the medical schools' Educational Affairs Committee, continuing medical education units, admissions officers and financial aid officers.

CATEGORY I COURSES/*continued*

Date: June 5-9, Psychology of Aging. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 30 hours of Category I Credit.

Date: June 5-16, Biology of Aging. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, MI 48109. **Approved for:** 30 hours of Category I Credit.

Date: June 7, 14 and 21, Gastroenterology/Family Practice. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital. **Cost:** None. **Contact:** R. W. Pomeroy, MD, E. W. Sparrow Hospital.*** **Approved for:** 3 hours of Category I Credit.

Please note dates of Keyport-Gaylord Trauma Symposium June 22-24. They are changed from previous announcements.

Date: June 22-24, Keyport-Gaylord Trauma Symposium. Location: Gaylord. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $25. **Contact:** Wayne State University, Division of CME,** or Benjamin E. Henig, MD, 308 Michigan Ave. Grayling, 49738. **Approved for:** 12 hours of Category I Credit.

Date: June 25-30, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $200. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21½ hours of Category ICredit.

Date: June 29-30, Mental Health in Aging. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology and U-M Medical School. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, University of Michigan, 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

Date: July 31-August 4, and November 6-10, Principles of Milieu Practice: Working with the Elderly in Treatment Settings. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 35 hours of Category I Credit.

Date: Sept. 13, Third Annual Renal Disease Conference. Location: Kalamazoo Center, 100 West Michigan, Kalamazoo, Michigan 49006. **Sponsor:** Michigan Nephrology Center. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians, Internists, General Practice, Nephrologists. **Cost:** $35. **Contact:** Jeffrey Block, M.D., Michigan Nephrology Center, 1521 Gull Road, Kalamazoo, Michigan 49001. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 28-29, Coping with Changes in the Later Years. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

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Legislative Day speaker turns biased view on Washington

By Willah Weddon
***Special to* Michigan Medicine**

Mark Russell banged on the piano, peered into the packed audience and thundered, "The new subway was needed in Washington . . . to keep crime off the streets."

Russell has been knocking politicians verbally for the past 16 years during nightly performances at the Shoreham-Americana's cocktail lounge. And they love it.

"TM (Transcendental Meditation) is sitting in one spot, thinking of nothing. That's been going on here in Washington for years," he continued. "TM gives people a feeling of serenity. The FDA will soon declare it illegal."

The 44 year-old humorist contends he doesn't belong to a political party. "I'm a confused Independent who can't be bought," he says and takes jabs at politicians on both sides of the aisle.

"I miss Sam Ervin," he said. "The only Senators left are cookie cutters."

"He's the kind that wouldn't stop running if he fell in a pail of Kaopectate," Russell quipped about another Senator. Then he leered through black, horn-rimmed glasses and accused listeners of remembering this one line only when they returned home.

He spews out a monologue in a voice capable of shaking lamps off walls, then stands behind a piano and pounds out his own accompaniment to songs he's composed. A three-piece orchestra comes in when he's been "on stage" half-an-hour, a signal for him to leave.

"Nine thousand drummers in the world," he said, pointing at the musicians, "And we had to get a guy who went metric two years ago."

Russell agreed to an interview after his last show while this writer was attending an AMPAC meeting. He was sipping his favorite beer backstage in a dimly lighted corridor furnished with a small round table and three chairs. It was remarkably unpretentious for a comedian who gets $2,000 for an out-of-town appearance.

Mark Russell

Insisting he has one brown eye and one blue one, the black-haired artist said he was born in Buffalo, New York and began playing the piano when he was seven years old, "because we had no piano before then." After serving in the U.S. Marines for three years he entered show business.

"I was a piano player originally, but not too good," he explained. "So I played less and talked more."

"I'm in the same union as Van Cliburn," he grinned. "It's obscene."

"I get my material by reading the newspapers," he said. "No TV, you can't get it that way." He doesn't use notes during his show, either. "I just start out and go on from there."

In addition to giving two performances five nights a week, Russell tapes shows for Public Broadcasting Service television and writes a syndicated newspaper column. "Actually, I print it on a legal pad," he clarified.

Describing his marital status as "no longer married," Russell lives in the Washington area with his three children, Monica, 17; John, 11 and Matthew, 9.

Does he stand off from the political scene to see the humorous aspect from a detached view?

"No," he concluded, "I look at it biasedly." ◥

Mark Russell featured at Legislative Day April 18

MSMS Auxiliary's annual Legislative Day will feature Mark Russell, a bell-ringer in the humor department, April 18, 12:45 pm, in the Olds Plaza, downtown Lansing.

Many MSMS and MSMS-A members have witnessed Russell's performances at the Shoreham Hotel while attending American Medical Political Action Committee (AMPAC) meetings in Washington, DC. (See accompanying article.)

Although having live entertainment is a departure from previous Legislative Days, the objective remains the same: learning how to be effective in politics and becoming better acquainted with state legislators.

Mrs. Thomas (Jill) Berglund, Auxiliary legislative chairman, has arranged the event with assistance of the Michigan Doctors Political Action Committee (MDPAC). Registration will begin at 9 am, followed by informative talks on politics, a legislative update and an address by Vernon V. Bass, MD, Saginaw, president of MSMS. A buffet luncheon at noon, with legislators as guests, will precede Russell's appearance.

Attendance is also open to physicians and friends who want to participate in any or all of the day's activities. Cost is $10 per person. Send checks, payable to MSMS-A, to: Executive Office, PO Box 950, 120 W. Saginaw St., East Lansing, 48823. April 1 is the deadline.

Sen. Otterbacher wants to help shape NHI

By Willah Weddon
***Special to* Michigan Medicine**

A clinical psychologist with a doctorate in psychology, State Senator John R. Otterbacher has meshed his interests in health care and politics during the six years he's been in Lansing. His record indicates the two are compatible. His future plans include more of the same but on the federal level.

Describing himself as a "liberal Democrat in a conservative district," Otterbacher overcame the odds to win a seat in the House of Representatives in 1972. Two years later his Grand Rapids constituents elected him to the Senate and he is currently a candidate for his party's nomination to the US Senate post open in the November election.

Nursing home reforms

Soon after entering the Michigan Senate he headed the special committee to investigate nursing homes and subsequently introduced legislation for stringent reforms. When it failed to receive favorable action, Otterbacher noted some of his colleagues were being influenced by nursing home proprietors.

He decided to take the issue to the people, urging them to pressure the Senator in their district, and he has traveled almost incessantly throughout the state to accomplish this. He's confident today that his bill (S.B. 659) will be given final approval by both houses.

He has also introduced legislation to license and regulate agencies providing home health care and to qualify such programs for federal funds.

"We're trying to put in place a system that will provide a cost-efficient alternative to institutional treatment for those people who can't care for themselves due to age or infirmity," he explains.

As chairman of the Senate Health, Social Services and Retirement committee, Otterbacher authored bills establishing the statewide Emergency Medical Services system and developed a state program for control of kidney disease. He also introduced the Public Health Code Revision bill in the Senate.

Now that he is a candidate for nomination to the US Senate, his interests have emerged regarding health care on the national scene. He is an enthusiastic supporter of a national health program.

"Medicare and Medicaid are patchwork programs," he contends. "They, and a variety of other government programs have really built-in problems of both fraud and abuse, overlap and duplication." He attributes this to the fact that they involve eligibility. "With national health insurance you don't have that problem . . . everybody is eligible . . . so you can spend a greater amount of energy and effort on the questions of quality care, accessibility of care and high quality personnel."

NHI inevitable

"The national sentiment is so strong for it right now that there's no question but we will have national health insurance," he insists. So the real question is to set it up so it will work without the problems of other countries.

"A national health program could be a good thing or a disaster," he continues. "It is inevitable. Someone is going to write this program and my professional training could help be sure it's a good solid system."

Otterbacher is convinced President Jimmy Carter is going to push a national health program, "and push it hard." But Otterbacher believes such a program probably "won't float" until the end of this year at best.

With that time table, 35 year-old Otterbacher could be in Congress to help compose the legislation.

Otterbacher on physician accessibility:

Q: Are you familiar with the national Public Law 94-484, which declares health professional personnel a national resource (and fixes the federal government's responsibility for assuring that such personnel are available to meet the health care needs of the American people)?

A. No. But obviously when you get down to accessibility of health care as a right of citizenship in this country, government does have a responsibility to try to see that people have access to physicians . . . When we have such vast discrepancies between the availability of physicians in some of our urban-suburban and rural communities, that's part of an accessibility problem.

Q. You know physicians don't have to practice medicine unless they want to?

A: Surely. As to the argument that we're going to run out of physicians, well that's not all that likely. People still are standing in line to get into medical schools and if, as a matter of fact, some people decide they don't want to go to medical school because they don't like the rules and regulations established in government or elsewhere, then other people will take their places. I know that's not a very popular thing to say, but let's be realistic about it, a lot of people would like to provide medical services. It's a very honorable profession, probably the most esteemed profession in our society. We're not in real danger that people will cease going into that profession.

Sen. Otterbacher

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Business

Doctor Papo has organized practice well

Michael Papo, MD, right, and James Botsford, MD, take a break in Papo's office which is considered the nerve center of the Chelsea Medical Clinic.

When Michael Papo, MD, director of the Chelsea Medical Clinic, and James H. Botsford, MD, began their partnership in a small store in downtown Chelsea in 1958 they took care of approximately 4,000 patients a year.

But how things have changed!

"Now we take care of 100,000 patients annually," Doctor Papo says with satisfaction. Throughout their growth the emphasis has been on the family physician and his relation to each patient, he adds.

"If you want something done, ask a busy man," he quipped when asked how such an accomplishment was achieved. As he continued, however, it became apparent that organization . . . implemented with a dash of innovation . . . has played a major role in the success story of the Chelsea Medical Center.

Six-building complex

In 1967 the doctors Papo and Botsford moved into newly constructed facilities located on 40 wooded acres inside the village limits. The complex contains six brick buildings. There are a medical clinic, an independent medical laboratory, pharmacy, eye clinic, dental building, emergency room, surgicenter and a 120 bed community hospital. The latter three are joined by a covered walkway.

The physical arrangement itself sets the tone of organization. A first-time patient is greeted in the Clinic, the building in the front. Receptionists here have ledgers large enough to allow them to make appointments for 10 physicians. Four of these are located in suites within the same building. Each suite consists of two consultation rooms, four examining rooms and a waiting room. The doctor and nurse stay in their own area and the patient is taken to them from a main waiting room.

In the center of the Clinic is a nonfluoroscopic X-ray unit. If tests are needed, the independent clinical laboratory on the grounds provides immediate results.

Patients seeking medical care are classified as either emergency or walk-in patients. This minimizes clutter in the emergency room and reduces costs to the patient, Doctor Papo said.

Business side organized

Organization also is evident in the business aspect.

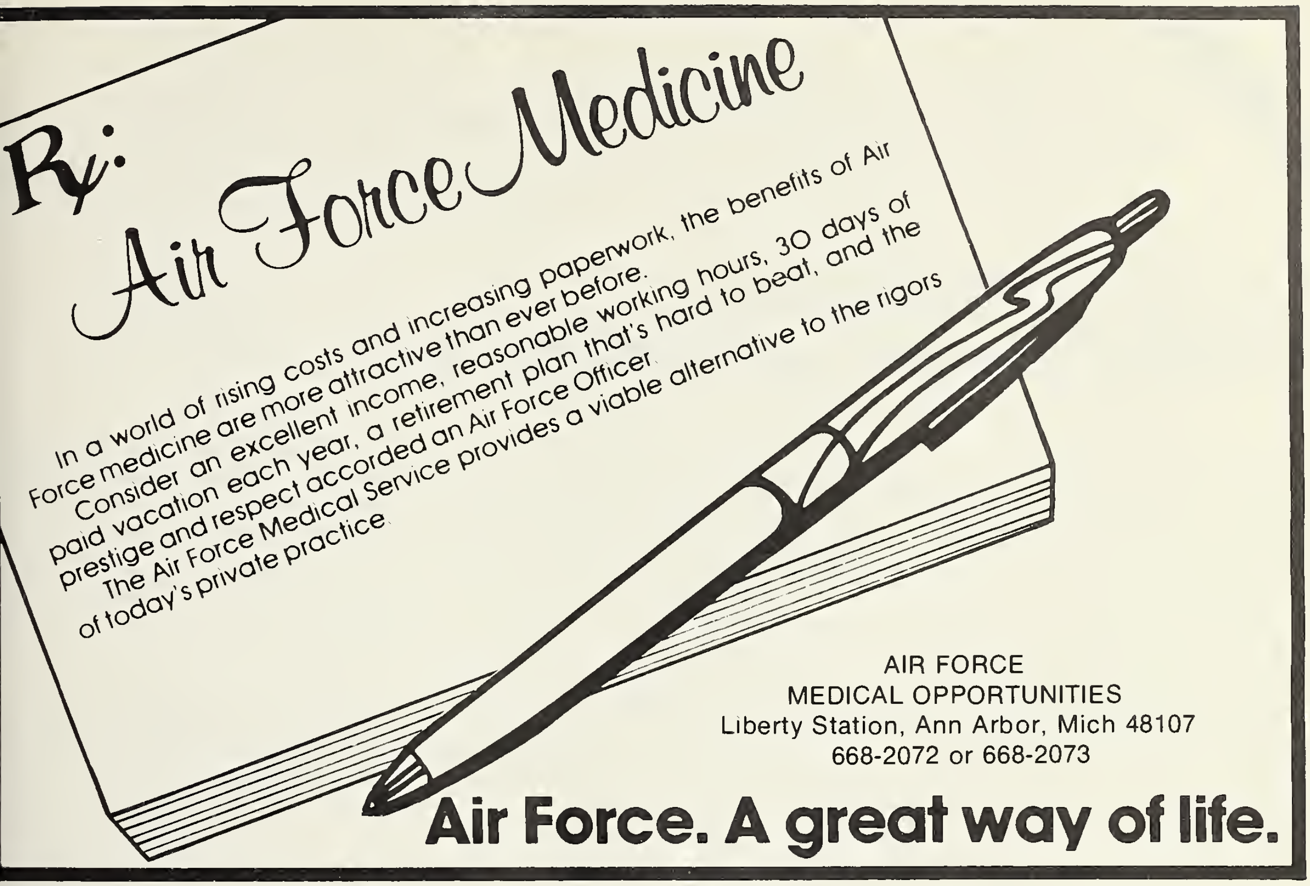
"After a bad experience with two computer companies . . . having lost a lot of money and developed a poor relationship between patients and doctors . . . we devised our own billing system." Two large, semi-automated machines are used for posting accounts. They can automatically produce insurance forms as well as patient statements. The information is fed into the machine by an operator who then can have it brought back and reproduced on an insurance form. It works, too. Doctor Papo said they have a very high percentage of payment in Medicaid billings.

In another room, sliding cases from floor to ceiling contain individual patient charts which are filed by number and cross filed by name on an index. Furthermore, all records are problem-oriented and color-coded for easy retrieval. There are 80,000 active charts in the Clinic alone.

Currently nine full-time and 14 part-time medical doctors are at the Center, in addition to 30 employees. Doctor Papo has an administrative assistant.

Born in Yugoslavia, Doctor Papo was placed in a concentration camp during World War II. After the war, he studied medicine in Rome, Italy. He came to the United States at the age of 26, in 1951, and entered the University of Michigan Medical School. He is the father of two college-age children and his hobbies are skiing and sailing. Ironically, it was his interest in sailing that led to a broken leg when he slid while trying to christen a new boat. The accident gave him time to contemplate, however, and he regards it as a turning point in his life.

"I decided we should become more involved in teaching, rather than just practicing medicine, as this is where the greatest need exists," he said. As a final step in this change of direction, the University of Michigan and the Chelsea Medical Clinic have now completed arrangements to locate the patient care unit of the medical school's new Family Practice Department in the Chelsea Clinic. "All our visions are coming to fruition," Doctor Papo said. — WW



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Careful handling of written consent minimizes risk

(The following is the fourth in a series of articles on risk management to appear in Michigan Medicine. It is sponsored by the MSMS Committee on Professional Liability, chaired by Robert M. Leitch, MD, Battle Creek, MSMS immediate past president. The material was originated with the Illinois State Medical Society, which has prepared tape cassettes on the subject.)

If you perform surgery, X-ray therapy or other major procedures without the patient's written consent, you're inviting a malpractice suit. In fact, before providing any medical service, you should discuss the therapy and obtain the patient's permission.

However, written consent will not protect you if you withhold important facts which may influence the patient's decision to accept or reject the treatment. Patients have a legal right to refuse medical care, and some may exercise that option when informed of the possible complications. That's why you should disclose the dangers inherent in any treatment before you obtain the patient's signature on a consent form.

Although disclosure requirements are not well-defined, a careful explanation of these three items is usually enough to satisfy the courts:

(1) The exact procedure or extent of therapy;
(2) Forseeable risks versus expected results; and
(3) Available alternatives and your recommendations.

You must provide the patient with sufficient information to enable him to make a responsible decision. A patient who claims he was not adequately informed will be required to prove in court that your explanation dd not meet the accepted disclosure standard. That is, he must prove that you omitted facts which a reasonable medical practitioner would have disclosed under similar circumstances.

Explain any risks and alternatives in simple language. Be honest and completely candid, and emphasize there are no guarantees of success.

Place a notation in the patient's chart summarizing the information you furnished and indicating that the patient was given an opportunity to consider the pros and cons before he granted his consent. If a patient refuses surgery or a recommended treatment, obtain a written statement to that effect.

All consent statements should be signed in the presence of a least two witnesses. These witnesses should be individuals who know the patient well enough to testify in court that he was of sound mind when he signed the form. Record the addresses of the witnesses so they can be located if a suit is filed.

Do not assign nurses or other hospital personnel to obtain consent signatures. Operative procedures should be explained by the surgeon, and he should person*ally* obtain the patient's signature both in the office and the hospital to fully document that adequate information was provided.

Illinois law provides liability protection for physicians who provide emergency care without the patient's consent. If you have not had prior notice of an illness or injury — and provide care in good faith without charging a fee — you cannot be held liable for your acts or omissions. In these cases, you are liable only for willful or wanton misconduct. You also can render care to a minor without parental consent if you believe that a delay in obtaining a parent's permission would adversely affect the child's health.

This information is advisory only and is *not* intended to imply or establish a standard of care, or to substitute for advice of personal legal counsel.

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Committees

MSMS adds new dimension to journalism study at Michigan State University

Journalism students at Michigan State University will have an opportunity to develop better understanding of medical problems and issues at a special half-day Journalism Student Seminar sponsored by the MSMS Committee on Public Service on April 19 at the MSU Union Building. The purpose of this workshop is to acquaint students with the medical profession's concern for public health and to expose them to medical issues.

The workshop will kickoff with a panel discussion by physicians and journalists on the issues of medicine. This will be followed by another panel on "sources for medical reporters" with medical and press representatives serving as resource persons. The workshop will windup with "The Press Conference," when the students will have a chance to bombard the experts with questions, much as they would when they become working reporters.

The Chairman of MSU's School of Journalism, George A. Hough, III, PhD, agrees this seminar will be a valuable addition to the students' curriculum.

By Katie Brewbaker, MSMS Staff

The new MSMS Task Force on Medical Care Costs has begun identifying ways in which Michigan hospitals and physicians can help contain health care costs. The committee is chaired by Frederick F. VanDuyne, MD, Flint, head of table.

Will the Blues' 94000 group plan be replaced?

The newly created MSMS Task Force on a Model Health Insurance Plan has begun its investigation of the merits of replacing MSMS's current coverage by Blue Cross/Blue Shield with coverage by an indemnity company. Other issues the Task Force defined at its initial meeting on February 1 as primary areas of study are a health benefit package including deductibles and co-payments as part of an MSMS group package, discussion of what features a model plan should include, and development of alternative ways of administering a health care program.

The Task Force was appointed by The Council in accordance with the instructions of the House of Delegates which stipulated that "in the event the differences that currently exist between BCBSM and physicians cannot be resolved, to investigate a model health insurance plan to replace the BCBSM 94000 Group Plan for MSMS members via the Michigan Physicians Mutual Liability Company or other carrier."

Birthing centers studied

Birthing alternatives is one of the subjects studied by the Committee on Maternal and Perinatal Health at its recent meeting. With an increasing interest among expectant parents in this subject, the Committee believes it is important physicians keep abreast of current developments. Members will review a slide presentation on the Birthing Center at Providence Hospital at a future meeting as part of its continuing study.

Also reviewed were several desk reference cards. Currently being updated are cards on toxemia of pregnancy pre-eclampsia, septic abortion, and family planning and contraceptives. New cards are being developed on standards of perinatal nutritional care, general anesthesia in obstetrics, neonatal hyperbilirubinemia, and gestational trophoblastic neoplasms.

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

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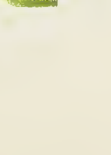

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News

By Katie Brewbaker, MSMS staff

President-elect of the American Section of the International College of Surgeons is **Meyer O. Cantor, MD,** Bloomfield Hills. Doctor Cantor assumes the presidency in November, 1978.

Robert M. Nicholson, MD, Kalamazoo, becomes president of the Michigan Association for Medical Education in May of this year.

University of Michigan Medical Center Senior Resident **John McCravey, MD,** joins the ranks of Michigan physicians competing in marathon running events. In addition to participating in races, Doctor McCravey coaches young people in the area in long distance running for the Junior Olympics.

Newly-elected speaker of the Council of the American College of Emergency Physicians is **John A. Rupke, MD,** Grand Rapids.

Recipients of awards for winning papers at the MSU College of Human Medicine's recent Statewide Conference of Medical Research in Family Practice are **Gary Ruoff, MD,** Kalamazoo, for the paper most relevant to family practice on "Five-Year Study of Colestipal HCL in Hypercholesterolemic Patients in a Family Practice," **David M. Woodliff, MD,** Hastings, best paper by community physician entitled "Role of Gastrointestinal Endoscopy in Primary Care," and **Kenneth S. Berneis, MD,** Kalamazoo, whose paper on "Office Detection and Management of Hypertension: The Use of Home Blood Pressure Monitoring" was judged the best by a family practice resident.

Ann Arbor physicians **Barbara J. Gruebel, MD; Stanley Sherman, MD;** and **Thomas Damuth, MD,** and **Steven J. Danek, MD,** Birmingham, are recipients of the Michigan Lung Association's Christmas Seal Fellowship award given to physicians-in-training at the University of Michigan Medical Center.

Three of the award winners at the first Michigan Family Practice Research Day are congratulated by Roy Gerard, MD, second from right, chairman of family practice at Michigan State University. Honors went to: (from left) David M. Woodliff, MD, Hastings family practitioner; Anne M. Pawlak, student at Michigan State University's College of Osteopathic Medicine, and Gary Ruoff, MD, Kalamazoo family practitioner. (MSU Photo)

H. C. Tien, MD, Lansing, received the Congress Award and Medal at the First Regional Convention of the International Association of Social Psychiatry.

Kenneth J. Ray, MD, Trenton, has been appointed a member of the AMA's Council on Medical Service.

Governor William G. Milliken appointed East Lansing orthopedic surgeon **James H. Bullock, MD,** to the State Board of Massage. Doctor Bullock has served as assistant clinical professor of surgery at the MSU College of Human Medicine and is chairman of the Infection Committee at Ingham Medical Center.

Ralph Blocksma, MD, well-known for his humanitarian and civic contributions, is the subject of a recent feature article in the *Grand Rapids Press* about special people in the Kent County area.

Elected to a fifth consecutive two-year term on the board of directors of the American Cancer Society is **Harold E. Bowman, MD,** Grand Rapids.

A three-day urology seminar was conducted in Guadalajara, Mexico by Grand Rapids physician **Dewey R. Heetderks, Jr., MD.** The seminar is sponsored by the Christian Medical Society for the Guadalajara Medical School.

Thespian **William D. Simpson, MD,** played a leading role in Eugene O'Neill's "Long Day's Journey Into Night" at the Grand Rapids Civic Theatre.

Arthur F. Kohrman, MD, has been chosen by the MSU Board of Trustees to fill the newly created position of associate dean of educational programs at MSU's College of Human Medicine. In his new capacity, Doctor Kohrman will be in charge of undergraduate, postgraduate, and continuing education involving graduate physicians and over 400 student doctors on campus and in community programs throughout the state.

Herbert A. Raskin, MD, Southfield, has been appointed to the Governor's Advisory Commission on Substance Abuse; board of directors, Committee on Problems of Drug Dependence, Inc., as a representative of the American Medical Association.

Bruce L. Danto, MD, Detroit, president-elect of the American Association of Suicidology, begins his tenure as president in April, 1978.

Recipients of the Wayne State University Distinguished Alumni Award for 1977 are **Peter Martin, MD; Herbert Raskin, MD,** and **Jack Ryan, MD.** Doctor Martin was cited for his outstanding work in psychiatry and as a leader in stimulating public involvement in mental health issues. Doctor Raskin was recognized for his contributions to the understanding of drug and alcohol dependency and his efforts to have the abuser perceived as a patient requiring individualized care. Doctor Ryan was honored for his long history of involvement with the Medical Alumni Association and his contributions as a faculty member of the School of Medicine.

John E. Smialek, MD; Joseph R. Monforte, PhD, Regine Aronow, MD, and **Werner U. Spitz, MD,** all of Detroit, are co-authors of an article in the December 5, 1977, issue of *JAMA* entitled, "Methadone Deaths in Children: A Continuing Problem."

D. Emerick Szilagyi, MD, Ann Arbor, and **Joseph P. Elliott, Jr., MD,** Detroit, received a Cine Clinic Plaque for their teaching film, "Anastromotic Aneurysm of the Common Femoral Artery" at the recent Clinical Congress of the American College of Surgeons in Dallas. The Cine Clinic program is jointly sponsored by the College's Medical Motion Picture Committee and Davis & Geck.

Recipient of the Alumni Achievement Award at Hillsdale College is **Leo J. Bingley, MD,** associate director of medical education and director of internal medicine education at St. Joseph Hospital in Flint.

The new U-M center for research in cancer, stroke, heart disease, and arthritis has been named after longtime faculty member **H. Marvin Pollard, MD,** who will help select staff for the Pollard Institute of Medical Research. Doctor Pollard is past president of the American Cancer Society and the American College of Physicians, and former chief-of-staff of the medical school's gastroenterology section.

Walter M. Belenky, MD, has been appointed chief of the Department of Otorhinolaryngology at Children's Hospital of Michigan in Detroit.

President-elect of the Michigan Health Council is **C. Allen Payne, MD,** Grand Rapids pathologist. Doctor Payne is a past president of MSMS and has served on numerous committees of the Society.

New Michigan Governor of the American College of Cardiology is **Sol D. Pickard, MD,** associate physician of the Division of Cardiovascular Diseases at Henry Ford Hospital in Detroit.

Alan M. Giddings, MD, proves you can't keep a good man down. The 93-year-old Battle Creek physician, who has been in practice for 63 years, broke his hip in December. But he healed so quickly that he was sent home in January, using a walker he says he intends to discard as soon as possible.

Doctor Danto

Doctor Blocksma

Doctor Cantor

Doctor Pickard

Doctor Rupke

Doctor Herald

Osbie Herald, MD, Muskegon, has been appointed the first full-time director of emergency services at Hackley Hospital. Doctor Herald served as president of the Muskegon County Medical Society in 1976 and was appointed to the Medical Practice Board by Governor Milliken in 1977.

The first chairman of the U-M Medical School's newly created Department of Family Practice is **Terence C. Davies, MD.** Dr. Davies comes from Mobile, Alabama, where he served as professor and associate chairman of the Department of Family Practice at the University of South Alabama College of Medicine.

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Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Holland 49423

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Ann Arbor 48109

William W. Bakken, MD
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Sparrow Hosp. Dept. of Rad.
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Shiow Jane Gu, MD
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AMA's proposed new principles of ethics need physicians' comments, suggestions

The American Medical Association is seeking comment from American physicians regarding proposed revision of the AMA's Principles of Medical Ethics.

The amendments proposed by the AMA Judicial Council are intended to modernize the language of the Principles and to clarify their meaning. The changes are on the agenda of the AMA House of Delegates for the Annual Convention in June, 1978, in St. Louis.

Comments and suggestions should be addressed to:

Bruce Nortell, Secretary, AMA Judicial Council, American Medical Association, 535 N. Dearborn St., Chicago, 60610.

Following is the proposed new version of the Principles:

Proposed new principles of medical ethics

Preamble. These principles are intended to aid physicians in maintaining high standards of ethical professional conduct in their relations with patients, colleagues, members of allied professions, and the public.

1. The primary objective of the medical profession is to serve patients competently with full respect for their dignity.

2. Physicians should strive continually to improve medical knowledge and skill and to make available to patients and colleagues the benefits of their professional attainments.

3. A physician should not engage or participate in treatment which is not founded on a scientific basis.

4. The medical profession should protect the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of their profession, and voluntarily accept its self-imposed disciplines. Physicians should expose, without hesitation, illegal or unethical conduct of members of the profession.

5. Physicians may choose when they will serve except in emergencies. Competent services should be provided and continued until the physician is discharged or services are discontinued after giving adequate notice. A physician should not attempt to obtain patients by deception.

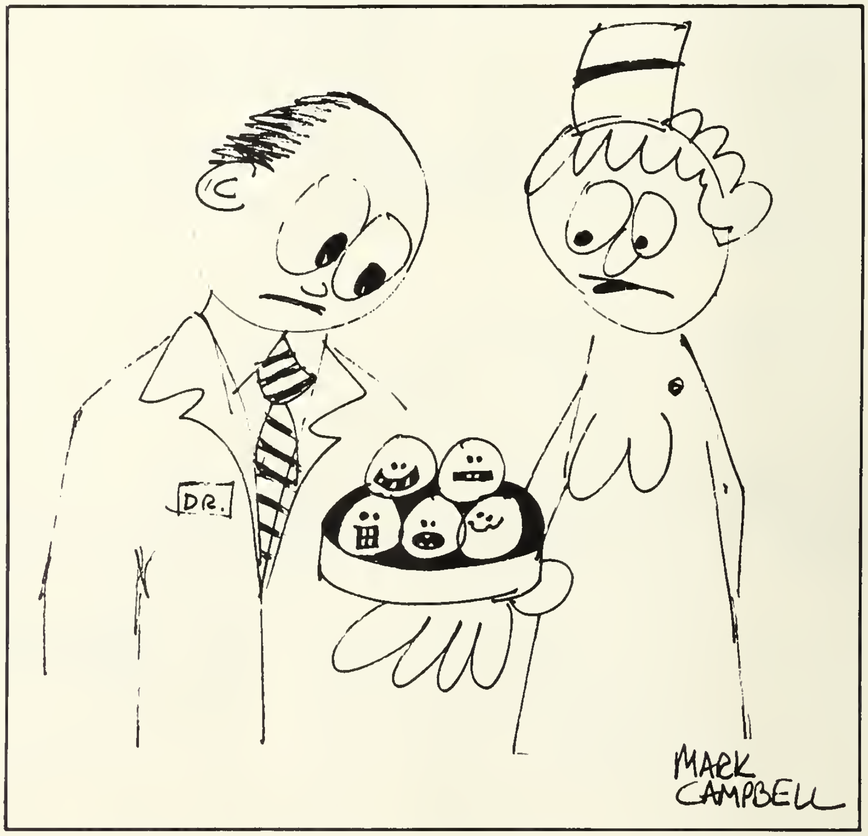
6. Physicians should resist restraints which interfere with medical judgment and skill or cause deterioration of the quality of medical care.

7. Physicians are entitled to be compensated fairly for personally providing or supervising the medical care of patients. A commission should not be paid nor accepted for the referral of patients.

8. A physician should seek consultation upon request or whenever it may benefit the patient.

9. A physician may not reveal confidences entrusted during medical attendance or deficiencies observed in the character of patients, unless required to do so by law or it becomes necessary in protecting the welfare of the patients or the community.

10. In addition to providing care to patients, the physician has a social responsibility to participate in activities intended to improve the health of the community. ◥



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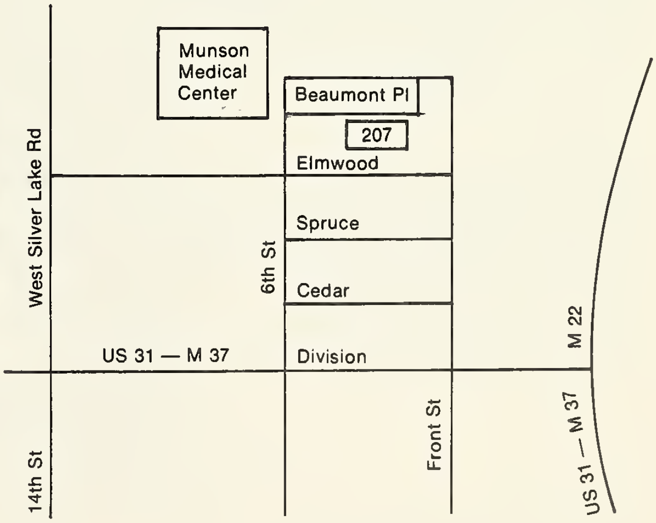
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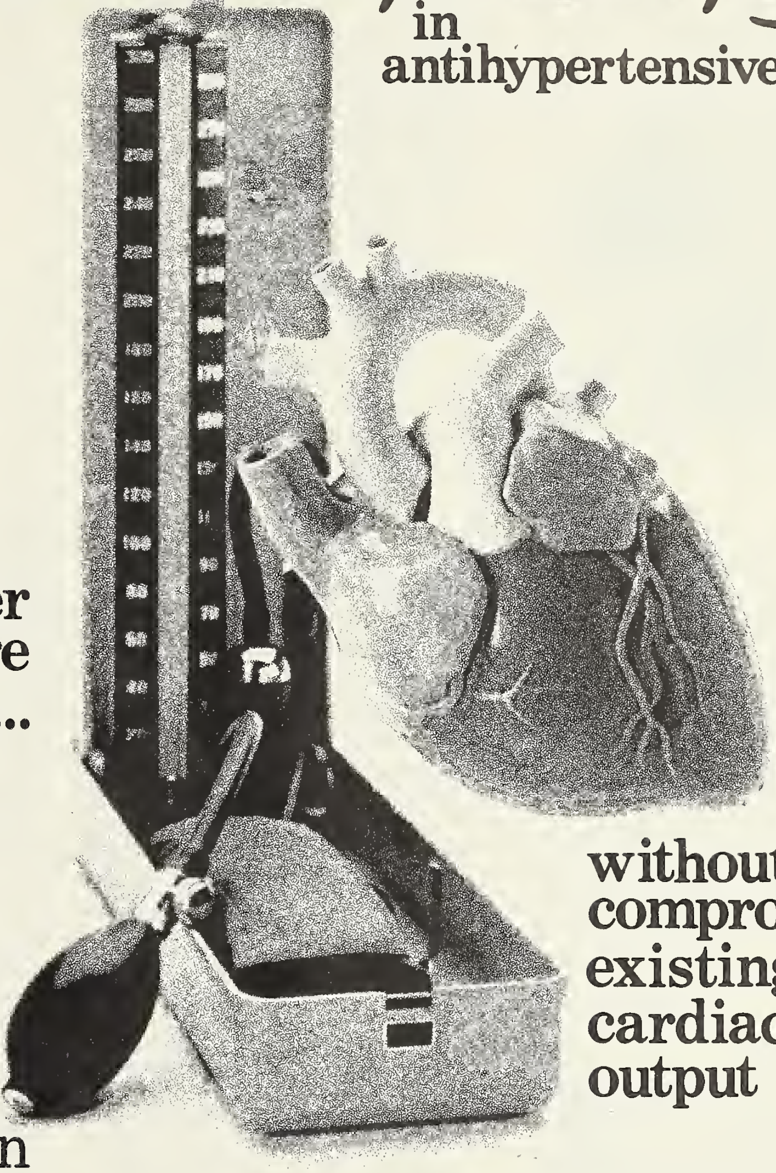

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For a brief summary of prescribing information, please see following page.

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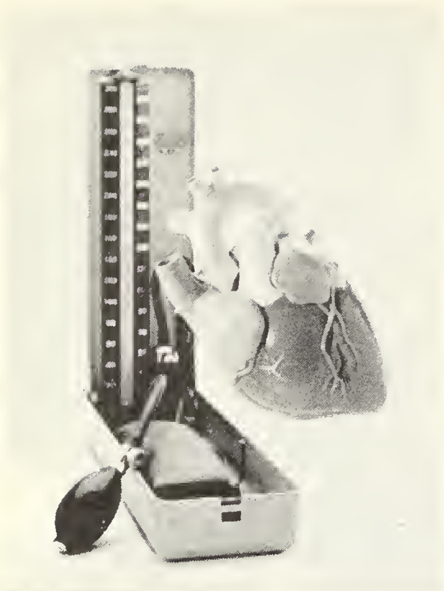

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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

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Deaths

Hector St. Amour, MD
Birmingham

Hector St. Amour, MD, Birmingham cardiologist, died Jan. 16 at the age of 82. Doctor St. Amour graduated from the University of Michigan Medical School and was on the staff of Veterans Hospital in Allen Park. He was formerly on the staffs of Grace and Crittenton hospitals.

Thomas A. Barton, MD
Howell

Thomas A. Barton, MD, of Howell, died Jan. 10 at the age of 57. A graduate of the University of Michigan Medical School, he was affiliated with McPherson Community Health Center, Howell. He had served on the Comprehensive Health Planning Council and was currently a member of the Southeast Michigan Health Systems Agency. On several occasions he was a delegate to the MSMS House of Delegates. Doctor Barton served on the MSMS State Legislation Committee for a number of years as well as several ad hoc committees of MSMS. He was a past president of the Livingston Cunty Medical Society and was a member of the American College of Chest Physicians.

Carl D. Burns, MD
Petoskey

Carl D. Burns, MD, Petoskey, founder and director emeritus, Burns Clinic Medical Center, P.C., died Feb. 9 at the age of 82. Doctor Burns received his medical degree from Rush Medical College of University of Chicago. He served as a student instructor in the Department of Materia Medica and Toxicology in the University and at Rush, and as instructor in the same departments in the Presbyterian Hospital School of Nursing, Chicago. Membership in medical organizations include Northern Michigan Medical Society, past-president; American College of Surgeons, recipient of Medical Records Honor Award; Michigan Chapter ACS; International College of Surgeons; and admission by election to Fellowship Royal Society of Health (Great Britain). Doctor Burns' hospital affiliations were Petoskey Hospital, where he was past chief of staff, and Little Traverse Hospital, of which he was co-founder, medical director, chief of staff and director emeritus.

Winston B. Jackson, Jr., MD
Detroit

Winston B. Jackson, Jr., MD, 50, Detroit, died Dec. 26. Doctor Jackson served as a neurologist on the staffs of Southwest Detroit Hospital, Kirwood Hospital in Detroit, Annapolis Hospital in Wayne and Outer Drive Community Hospital in Lincoln Park. He studied medicine at Howard University, Washington, DC, and neurology in the Veterans Administration Hospital in Allen Park. He was a US Navy veteran of World War II.

Frank H. Power, MD
Traverse City

Frank H. Power, MD, Traverse City, died Jan. 27 at the age of 69. A graduate of Northwestern University Medical School, Doctor Power was a past president of Grand Traverse-Leelanaw-Benzie County Medical Society and a delegate to the MSMS House of Delegates. He was past president of staff at Munson Medical Center, Traverse City, as well as past chief of surgery there. He was a member of the Fredrick A. Coller Surgical Society, the Board of Surgery and the American College of Surgeons. Doctor Power served as mayor of Traverse City and was active in many committee organizations.

Robert C. Ries, MD
Rogers City

Robert C. Ries, MD, "pioneer" of Rogers City Hospital, died Jan. 13 at the age of 62. Doctor Ries was the only surgeon currently serving the hospital. He was a graduate of the Wayne State University School of Medicine and was a past president of Presque Isle County Medical Society. He was also a member of the FACS.

Harper G. Sichler, MD
East Lansing

Harper G. Sichler, MD, East Lansing, died Jan. 9 at the age of 73. A graduate of the University of Michigan Medical School, Doctor Sichler was affiliated with Clinton Memorial Hospital, St. Johns, as well as Hayes-Green-Beach Hospital Charlotte and St. Lawrence Hospital, Lansing. He was a member of the American College of Radiology and the Radiological Society of North America.

Vasily O. Vasu, MD
Kentwood

Vasily O. Vasu, MD, of Kentwood, died Jan. 3 at 80 years of age. Doctor Vasu was a graduate of the Loyola University of Chicago Stritch School of Medicine, Illinois, and was affiliated with Highland Park General and Brent General hospitals.

Marshall S. Williams, MD
Hancock

Marshall S. Williams, MD, a Hancock radiologist aged 52, has died. Doctor Williams was a graduate of the University of Michigan Medical School and was affiliated with St. Joseph Hospital, Hancock; Calumet Hospital, Laurium; Ontonagon Memorial Hospital, Ontonagon; LaCroix Hospital, White Pine; and Divine Infant Hospital, Wakefield. He was a past secretary of the Houghton-Baraga-Keweenaw County Medical Society, and was a member of the American College of Radiology as well as F. J. Hodges Radiological Society.

Classified

Positions open

OPHTHALMOLOGIST, relocating, desires to sell office and practice, $80,000 gross yearly. Area near Western Oakland County. Growing practice, excellent location two blocks from hospital. Very rapidly growing area. Patient load can be easily doubled. Please reply to Michigan State Medical Society, 120 W. Saginaw, Box 4, East Lansing, MI 48823.

POSITION AVAILABLE: EDUCATIONAL COORDINATOR FOR INTERNAL MEDICINE. Applications are now being accepted for this full-time position with the Southwestern Michigan Area Health Education Center. To be considered, an individual must be a Diplomate of the American Board of Internal Medicine.

Duties and responsibilities will encompass many areas of activity including undergraduate, graduate and continuing medical education. A complete job description is available on request.

Compensation will include a generous stipend and fringe benefits package as well as a regular appointment to the faculty of the College of Human Medicine of Michigan State University.

Interested persons should promptly submit an application in writing. A complete current curriculum vitae should accompany the application. For further details contact: Robert M. Nicholson, MD, Executive Director, Southwestern Michigan Area Health Education Center, Room #364, 252 East Lovell, Kalamazoo, MI 49007, 616/838-7896.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park, there are openings for physicians board qualified as internists, family physicians or psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently over forty thousand per year, plus 23 percent fringe benefits, including life, accident, long term disability, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7789.

STAFF PHYSICIANS — (East Lansing — Ingham Cty.) Michigan State University is currently recruiting for staff physicians. One of the 10 largest universities in the nation with an enrollment of over 40,000. Located in a metropolitan area of 250,000. The Olin Memorial Health Center, located on the campus, provides facilities for students in need of medical, acute surgical or psychiatric care. It is a well-equipped general hospital with a large outpatient section. Position would be full time with 30-day paid vacation. Physicians must be licensed to practice in Michigan or immediately capable of obtaining such license. Facilities include a completely outfitted office suite; no other equipment needed. Professional work is essentially in the category of general practice with surgery confined to the limits of the individual's experience. No pediatric, geriatric or obstetrical services provided. Staff physicians rotate on night calls and weekends. Fringe benefits include Social Security, term life insurance, malpractice insurance, and staff privileges for University cultural programs and intercollegiate athletic events. Minimum starting salary $30,000 annually. Contact: John D. Siddall, D.O., Director, Olin Memorial Health Center, Michigan State University, East Lansing, MI 48824.

MEDICAL DIRECTOR: For 206-bed chronic disease facility to work in a dynamic, challenging program with a progressive medical and paramedical team. Salary $43,000. Excellent fringe benefits as an employee of Macomb County: generous retirement program; longevity compensation; paid liability and professional malpractice; Blue Cross/Blue Shield with prescription rider; life insurance; 13¼ holidays; sick leave. Qualifications: Physician licensed to practice in

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New labeling for contraceptives in Federal Register

Completely revised physician and patient labeling for oral contraceptives are published in the *Federal Register* of January 27, 1978 by the Food and Drug Administration. A box warning will highlight the added risk of cigarette smoking to oral contraceptive users.

Physicians interested in this subject may write Alan S. Kaplan, MD, Director, HEW Office of Professional Programs, 5600 Fishers Lane, Rockville, Maryland 20857.

ONE OF THE REASONS SHE CAN WORK SO WELL AS PART OF A TEAM... IS BECAUSE SHE LEARNED TO WORK THAT WAY AS PART OF A PLATOON.

Guard and Reserve units are more important to national defense than ever before. As the *only* alternative to larger and more costly active forces, they must maintain a high level of readiness. To be ready, teamwork and team spirit are vital, which is why Guard and Reserve leaders try to instill these qualities in their people.

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Michigan. Special emphasis will be placed on additional qualifications specific to a chronic disease and long-term rehabilitation program. Contact Raymond D. Pietrzak, Administrator, Martha T. Berry Memorial Medical Care Facility, 43533 Elizabeth Road, Mt. Clemens, MI 48043. Phone 313/469-5623, ext. 24.

FAMILY PRACTICE PHYSICIAN OR INTERNIST, Applicant must be interested in General Family Medicine for five Integrated Clinics in city and suburbs. Complete laboratory and nuclear medicine. Foreign graduates must have state license. Liberal salary. Call or write TRAIL CLINICS, P.C., Cindy Papuga, Clinic Secretary, 18254 Livernois, Detroit, MI 48221, 313/861-4400.

DIRECTOR OF EDUCATION IN INTERNAL MEDICINE. A certified internist or subspecialist is needed for an administrative and teaching position in an Internal Medicine residency program affiliated with Michigan State University College of Human Medicine and Hurley Medical Center. McLaren General Hospital is a 469 bed, progressive, acute care hospital with general surgery, internal medicine, orthopedic, ob-gyn, and psychiatric training, and an undergraduate teaching program. Salary negotiable. Community offers excellent recreational and cultural opportunities. Inquiries to: Search Committee, c/o Mr. Gary R. Peterson, McLaren General Hospital, 401 Ballenger Highway, Flint, Michigan 48502, 313/762-2345 or B. S. Farah, MD, Chairman, Dept. of Internal Medicine, McLaren General Hospital, 401 S. Ballenger Highway, Flint, Michigan, 48502, 313/235-6663.

MEDICAL DIRECTOR — licensed M.D. or D.O. in Kalamazoo, Michigan. 40-hour week, no weekends, leisurely work doing physicals and reviewing charts. All malpractice paid, $30,000/yr. salary. Contact: Daniel Idema, V.P. of Operations, American Plasma Mgmt., Inc., 705 N. Park St., Kalamazoo, Michigan 49007, phone 616/245-9855 in Grand Rapids, MI.

PSYCHIATRISTS: Join well-run CMHC with proven professional programs. Do IP, OP, crisis, consultation. Possible academic appointment, new center. Stable funding, salary and fringe package high 30's to low 50's. Live in navy bean, sugar capital of Midwest, manufacturing center, international seaport, great cultural, educational, recreational area. Call or write Director, Saginaw CMHSC, 1314 S. Jefferson Avenue, Saginaw, MI 49601. Phone 517/752-4178.

PSYCHIATRIST WANTED FOR SW Michigan city for modern, progressive 90-bed general hospital with expansion planned; county population 72,000; near state forest and Lake Michigan; rural setting minutes away from major metro areas; recreational opportunities in a 4-seasons setting; excellent salary and fringe benefits. Contact W. Trent, Adm., Allegan General Hospital, 555 Linn Street, Allegan, MI 49010. Phone: 616/673-8424.

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Miscellaneous

BEAUTIFUL, rustic year-round cabin located in Central Eastern Upper Peninsula, includes 160 acres with 20 acre tree plantation, large fireplace, fully insulated, sleeps ten, separate sauna, completely furnished, good roads, excellent hunting, ideal for club or investment, contact Buckingham Real Estate, 224 Newberry Avenue, Newberry, Michigan 906/293-8771.

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SIX MEDICAL OFFICE SUITES — all new medical center in prime location of Brighton. 1150 square feet to 3000 square feet office units, includes four exam rooms or more, private office and entrance, laboratory, excellent parking, ideal to accomodate one or two doctors. Spring or summer occupancy. Call Davis Professional Bldg., 313/229-2752 or 313/229-7525.

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FOR SALE — Surplus certificates of Michigan Physicians Mutual Liability Company, for price of $1,700. Purchaser must be a licensed Michigan physician. Write: MSMS, Box 4, 120 W. Saginaw, East Lansing, MI 48823.

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of alcoholism,
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or other
difficulties
which interfere with
his/her abilities
to practice medicine?**

If so, please contact your MSMS Committee to assist Impaired Physicians, through Mrs. Davis at MSMS headquarters (517) 337-1351.

MICHIGAN STATE MEDICAL SOCIETY
18 66

12th annual program for team doctors, trainers, and coaches . . .

1978 Conference on Medical Aspects of Organized Athletics
Thursday, April 13, 1978
Hilton Inn, Lansing

(Saginaw Street exit off I-96)

Sponsored by Michigan State Medical Society

The Michigan State Medical Society will grant 6 hours of Category I Continuing Medical Education Credit toward the state requirements.

8 a.m. *Registration and Coffee*

9 a.m. Welcome: Edward M. Fugate, MD, Muskegon, Planning Committee chairman

9:15 a.m. **"Medical Screening Program for Athletes — New Concept Using Doctors, Trainers, and Coaches"**
Douglas McKeag, MD, Department of Family Practice and Sport Medicine, Michigan State University, East Lansing

9:45 a.m. **"Strength Testing as Part of the Physical Screening Examination"**
Clint Thompson, MS, Certified Athletic Trainer, head, Department of Athlete Training and Rehabilitation, Michigan State University, East Lansing

10:15 a.m. *Coffee Break*

10:30 a.m. **"Drugs, Society, and the Athlete"**
Donald L. Cooper, MD, director, Oklahoma State University Student Hospital and Clinic, OSU Team Physician, Stillwater, Okla.

11:00 a.m. **"Injury Prevention in Athletes"**
David C. Bachman, MD, director, Northwestern University Medical School Center for Sports Medicine, Chicago

11:30 a.m. **"Difference in Treatment Rules in High School and College"**
Allen Bush, Director of Athletics, Michigan High School Athletic Association, Inc., East Lansing

12:00 noon *Luncheon*

12:45 p.m. **"Competitive Athletics: A Plus in Higher Education"**
Joseph Kearney, Athletic Director, Michigan State University, East Lansing

1:15 p.m. **"Non-orthopedic Problems in Sports Medicine"**
David Hough, MD, Department of Family Practice and Sports Medicine, Michigan State University, East Lansing

1:45 p.m. **"On the Field Evaluation of the Injured Athlete"**
Donald L. Cooper, MD, director, Oklahoma State University Student Hospital and Clinic, OSU Team Physician, Stillwater, Okla.

2:15 p.m. **"Non-operative Treatment of Ankle Injuries"**
Ken Kopke, Certified Athletic Trainer, coordinator, Sports Medicine Service, Central Michigan University, Mt. Pleasant

2:45 p.m. **"Treatment and Diagnosis of Soft Tissue Injuries"**
Richard Hoover, head, Education Department, Northwestern University Medical School Center for Sports Medicine, Chicago

3:15 p.m. **"Trauma to the Foot: Diagnosis, Treatment, and Rehabilitation"**
David C. Bachman, MD, director, Northwestern University Medical School Center for Sports Medicine, Chicago

3:45 p.m. **"Conservative Treatment of Collateral Ligament Injuries to the Knee"**
Gerald A. O'Connor, MD, head, Department of Sports Medicine, University of Michigan, Team Physician, Ann Arbor

4:15 p.m. *Conference Ends*

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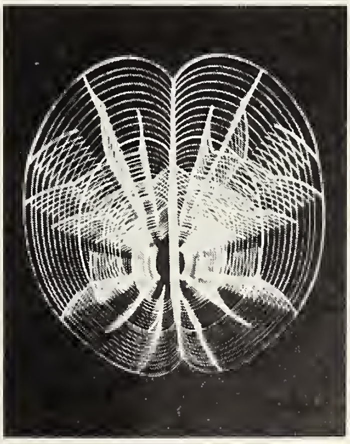

Before prescribing, please consult complete product information, a summary of which follows:
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
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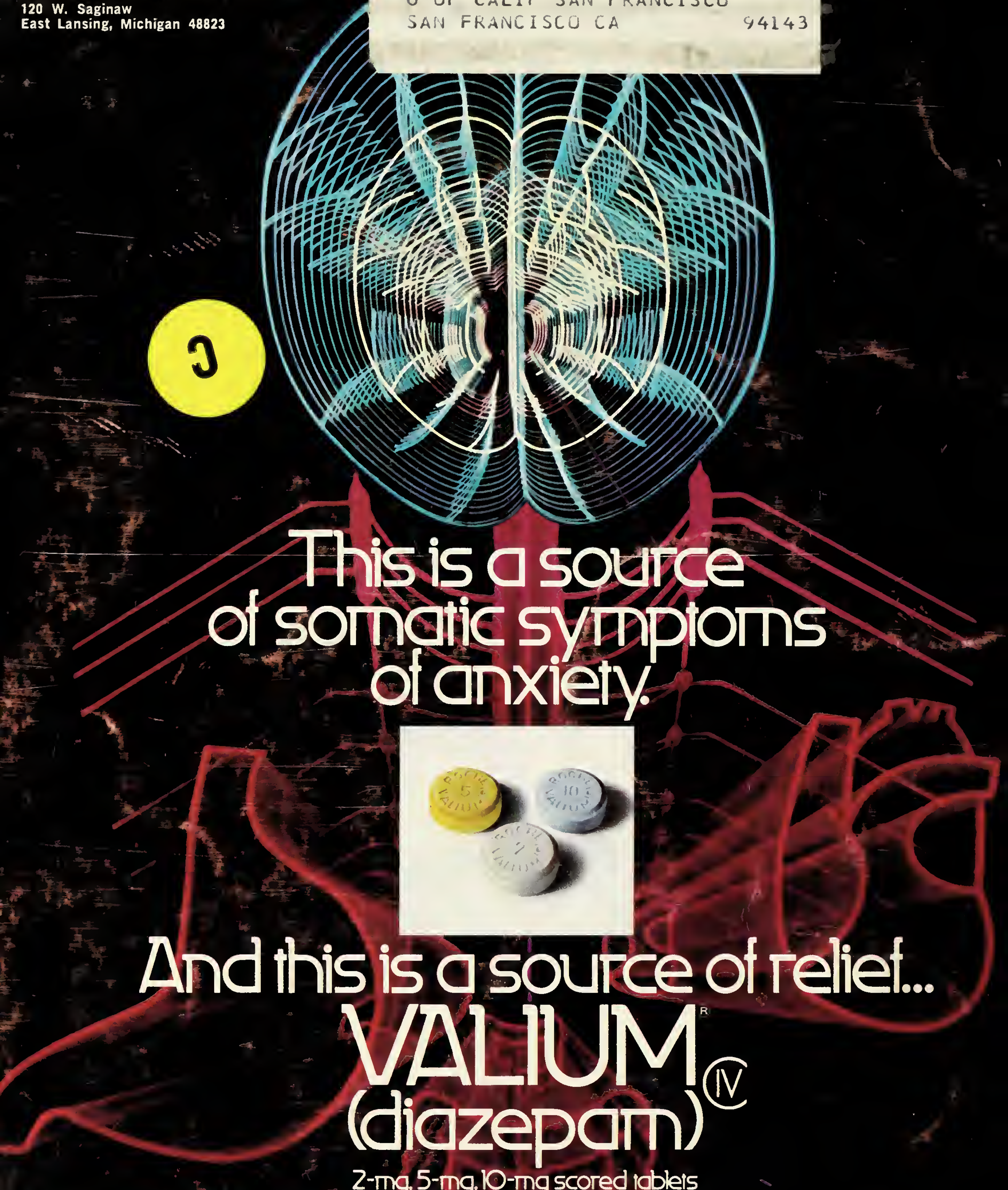

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 9 MARCH 16, 1978

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MSMS Council adheres to March 15 Blues date

Many Michigan physicians said they would departicipate with Blue Cross/Blue Shield of Michigan on March 15 in response to reimbursement changes instituted by the Blues in recent months. Michigan physicians extended their timing from Jan. 1 to March 15 at the Blues' request to allow BCBSM representatives to take to the BCBSM board physicians' requests that the Blues eliminate differentials in payment between participating and non-participating physicians. However, the Blues board on March 2 referred the physicians' proposals to various committees, once again delaying any action.

All this was reported March 8 to The MSMS Council by Donald K. Crandall, MD, chairman of Negotiations. Doctor Crandall described several meetings during the past two months between Michigan MDs and Blues representatives, when it became obvious the Blues still are unwilling to apply all aspects of their physicians reimbursement program equally to par and non-par doctors. After hearing Doctor Crandall's report, The Council reaffirmed the MSMS House of Delegates Oct. 26 decision calling for a protest of the discriminatory reimbursement policies.

The Council voted (1) to adhere to the March 15 date, and urge all physicians to withdraw from participation with BCBSM. In addition, The Council (2) authorized a steering committee to implement a member-information plan for doctors to departicipate, (3) authorized the steering committee to inform the members of possible alternate methods for billing patients who are BCBSM subscribers.

In other action, The Council voted to suggest the use of VISA and Master Charge systems in physicians' offices as a convenient method of payment by patients. MSMS is negotiating with the charge card systems on a statewide basis to secure a favorable service charge. Details on this will be coming. Complete details of actions to take once a physician has departicipated, and of options open for billing procedures are being shared with delegates.

MSMS OFFERS COUNTERSUIT OPTION

Recent public attention to countersuits against lawyers who have filed "unwarranted" malpractice litigation against physicians has raised questions about MSMS' position on these cases. Apparently a group of Detroit physicians is attempting to solicit funds from MSMS members to support the countersuit of Seymour Friedman, MD, Detroit.

The countersuit of Doctor Friedman is still pending in the Michigan Court of Appeals. If Doctor Friedman loses there, MSMS may file a strong amicus curiae brief in the Michigan Supreme Court. If the doctor wins, the case goes back to circuit court for trial on the merits. If that happens, MSMS legal counsel will recommend MSMS give financial support to Doctor Friedman's case.

MSMS will continue investigating current countersuits, to consider supplying legal research and back-up, amicus curiae briefs, or outright subsidizing of legal fees when appropriate.

The MSMS Council in 1976 directed MSMS legal counsel to continue its own countersuit analysis program. Currently, three cases are under consideration. Not as many potential countersuits have been submitted for MSMS evaluation as originally expected. The opportunities still are open for MSMS members who have experienced convincing court victories over malpractice charges. For information on the MSMS Countersuit Program procedures, please contact Mrs. Vada Davis at MSMS, 517/337-1351.

CONTACT DELEGATES FOR DEPAR INFO

MSMS members should contact their MSMS delegates for full details concerning departicipation with Blue Cross/Blue Shield of Michigan. The MSMS Council March 8 initiated a flow of full information to the delegates on courses of action available to physicians. Delegates will serve as primary sources for information. Kits of instructions on physicians' options will be available to all members shortly and will be published in the next Medigram.

STEPS TO TAKE IN DEPARTICIPATION

If you haven't yet cancelled your participation agreement with Blue Cross/Blue Shield of Michigan, and if you decide now to do so, simply write Louis F. Hayes, MD, Vice President for Provider Affairs, BCBSM, 600 Lafayette East, Detroit, 48226. MSMS suggests you indicate your plans to departicipate and give 15 days' notice.

ATTEND CONFERENCE
ON SPORTS-MEDICINE
LANSING HILTON HOTEL
THURSDAY, APRIL 13

MSMS Council actions

(1) Approved four actions in Michigan physicians' negotiations with the Blues (see related article in this issue);

(2) Authorized MSMS legal counsel to file an amicus curiae brief in the Texas pharmacists' case against Blue Cross/Blue Shield, which is now in the U.S. Supreme Court, because it has strong parallel issues with Michigan physicians' concerns;

(3) Approved an MSMS statement reacting to proposed federal regulations of sterilizations by Medicare, Medicaid and other public programs. The MSMS statement is to be transmitted to federal and state officials;

(4) Authorized MSMS President Vernon V. Bass, MD, President-elect Louis E. Heideman, MD, and Council Vice Chairman Louis R. Zako, MD, to coordinate work of the MSMS Task Force on Health Care Costs with work of a possible new committee to study the National Commission on Health Care Costs' report;

(5) Agreed to support a grant request for developing a new statewide emergency medical care system;

(6) Nominated Daniel J. Fall, MD, Ann Arbor, to a new Statewide PSRO Council;

(7) Received details of completed transfer of MSMS funds management to new advisors; and

(8) Accepted Board of Managers' report that construction of new headquarters annex is beginning after months of planning. The H/D Ways and Means Committee has been fully involved in the planning and periodic reports have been submitted to that Committee.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Vol. 77 No. 9, March 16, 1978

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BLUES COMMENTARY

By Donald K. Crandall, MD

Michigan physicians should work to convert Blue Cross/Blue Shield of Michigan to an indemnity company. This has been the position of the MSMS House of Delegates over the past several years.

The conversion of BCBSM to an indemnity company could be accomplished, I believe, by several methods, including legislation, legal decree, proclamation by the Insurance Commissioner, or decision by the BCBSM board.

But the quickest and most effective method individual physicians could use is for all MDs to departicipate from BCBSM programs. This would, in effect, make BCBSM like any other health insurance firm.

BCBSM is attempting to get complete control over the services physicians offer patients and fees physicians charge for their services. Some doctors, however, fail to see this at present.

The current level of BCBSM payments has improved somewhat because of the new screens instituted; however, when the Blues target limitation on expenditures program goes into full effect in 1979, the BCBSM payment level again will rapidly deteriorate. Then physicians will begin to see the full effects of BCBSM's reimbursement programs for what they are.

I hope Michigan MDs now will realize the destruction this will bring on our profession and the adverse effects this will have on the quality of care we offer our patients.

Let's work to protect our profession and the people of Michigan now.

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 10 APRIL 1, 1978

Both par and non-par doctors can help resolve Blues dispute

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By Vernon V. Bass, MD
MSMS President

By now the majority of Michigan physicians have made their decision to formally participate or not with Blue Cross/Blue Shield of Michigan. I respect that decision.

MSMS believes physicians have been made aware of the issues in the continuing dispute with the Blues. MSMS has felt from the beginning the Blues' policies have discriminated against patients as well as MDs, forcing patients to go to participating physicians by restricting a patient's free choice of doctor.

All physicians, par and non-par, have a stake in the outcome of the dispute and all doctors can aid in its resolution.

Concerned Michigan physicians are holding the line and continuing the fight for equal benefits for par and non-par doctors. Every doctor can help achieve these goals if they choose to take actions prescribed in this Medigram.

BCBSM has not won its campaign to expand formal physician participation in its programs. In fact, it has lost. BCBSM is far short of reaching its goal of 75 percent participating doctors.

Prior to the introduction of the Blues' new reimbursement policies, MSMS for the past three years had maintained the Blues should:

a. discontinue the area and specialty differentials in screens;
b. provide an annual automatic update of physician profiles based on current charge data.

With the Blues' new reimbursement policy effective Jan. 1, three incentives for participation were awarded -- but only to participating doctors. The three incentives are: (1) a one-time, rather than annual, automatic update of physician profiles, (2) a cumulative carryover of annual customary fee in-

Continued Page 3

To my fellow physicians . . .

April 1, 1978

Many of you have asked me for my suggestions that might be taken to help resolve our controversy with the Blues. You may wish to consider the following options.

IF YOU ARE A PARTICIPATING DOCTOR . . .

You may work to help make BCBSM systems more responsive to actual costs of medical care if you:

(A) Fill in your established fee when completing the DSR form, rather than listing the amount you are paid by BCBSM;

(B) Keep a ledger to track the difference between customary charges and payment received from the Blues. In most cases physicians will observe they are, in effect, discounting their services to the Blues;

(C) Continue to monitor your claims to BCBSM for promptness and accuracy;

(D) Continue to update profiles yearly.

IF YOU ARE A NON-PARTICIPATING DOCTOR . . .

You may wish to take the following courses of action:

OPTION #1 -- You may choose to fill out your own billing form, in place of the BCBSM form. If you choose this option, you should:

Write down on your own form the following items: doctor's name and address, date of service, procedure, diagnosis and charge.

This information should be given to the patient, who in turn should give it to the Blues. All other information presently required by BCBSM can be supplied by the patient.

OPTION #2 -- Continue to use the BCBSM claim form, filling in only the essential information listed above. If you choose this option, you should:

Instruct the patient to fill in the remainder of the form and send it to BCBSM.

OPTION #3 -- You may continue to complete the DSR form. If you choose this option, you should:

Check the pay provider box "no";

Instruct your office personnel to ask the patient to sign the form. This signature acknowledges the patient knows he is responsible for your bill. This is referred to by BCBSM as "establishing prior agreement." If the patient refuses to sign the form, inform him he is responsible for paying your bill and note this in his record.

IN ANY EVENT -- Non-par doctors should consider these steps:

Discuss the current Blues situation with your patients.

Instruct office personnel to ask for payment upon receipt of service.

Establish a billing system and effective collection procedure. The AMA Code of Ethics prohibits charging interest on overdue bills, but allows the addition of a "rebilling fee" equal to the actual additional administrative costs you incur by sending additional bills. The policy of charging for rebilling should be printed on the first bill the patient receives.

Arrange payment schedules if patients are unable to pay the full charge. The schedule should begin on the next regular billing date, not when the patient receives payment from BCBSM.

Inform the patient he will be expected to adhere to the payment schedule as it is his responsibility, not BCBSM's, to make payments.

Donald K. Crandall, MD

Doctor Bass discusses Blues/
continued from Page 1

creases, and (3) a statewide screen eliminating area/specialty differentials. The discrimination against nonparticipating physicians and their patients continues.

Also, MSMS is concerned by BCBSM plans for the unilateral introduction of its target limitation on expenditures in 1979. Under this punitive system, there exists the probability that physicians' screens (reimbursement) will be reduced if total participating physician expenditures exceed the Blues' budgetary cap.

MD negotiators, Blues' representatives to meet April 12

The MSMS Committee on Negotiations and the Blue Cross/Blue Shield of Michigan Committee on Professional Relations will hold another meeting April 12.

Results of the meeting will be included in the report the MSMS Negotiations Committee makes to the 1978 MSMS House of Delegates May 5-7. In addition, the committee is reporting at each of the 11 MSMS Councilor Conferences scheduled around the state this month.

In October, 1977, meeting in special session, MSMS delegates gave Doctor Crandall a standing ovation after hearing his report of the committee's representation of Michigan physicians in the dispute with the Blues over their reimbursement changes.

The delegates, after hearing the report, unanimously recommended all physicians in Michigan withdraw participation with the Blues.

COUNCILOR CONFERENCES SCHEDULED THIS MONTH

In preparation for the 1978 MSMS House of Delegates meeting, MSMS has scheduled its annual Councilor Conferences across the state.

The conferences, led by MSMS Councilors in each of their districts, assisted by MSMS staff, are designed to inform delegates about the issues and organization of the annual meeting.

The schedule and location of the conferences is as follows:
April 12--District 15, Troy Hilton Inn;
April 19--District 11, Century Club, Muskegon;
April 20--District 14, Mariott Inn, Ann Arbor;
April 25--Districts 3 and 4, Corsiglia's, Kalamazoo;
April 25--District 7, Fogcutter Restaurant, Port Huron;
April 26--District 5, Peninsula Club, Grand Rapids;
April 26--District 6, Flint Golf Club;
April 26--Districts 8 and 10, Bay Valley Inn, Bay City;
April 27--District 2, Win Schuler's, Jackson;
April 27--District 9, Holiday Inn, Traverse City;
April 29--Districts 12 and 13, Terrace Motor Inn, Escanaba.

UP Medical Society annual meeting April 28-29

Final program has been announced by A. Leslie Rose, MD, program chairman, 85th Annual Upper Peninsula Medical Society Meeting, April 28-29 in Escanaba. This year the program will focus on non-scientific subjects and will offer speakers on PSRO, professiona liability, medical care foundations, UP Medical Education Program, long-term care projects, medical costs, HSAs, MDPAC, and other topics. William J. Mangold, MD, San Antonio, vice chairman, AMA Council on Legislation, will discuss "Current National Health Insurance Legislation." The MSMS Committee on CME Programming has been involved in planning the program and will provide Category I credit to physicians who attend.

PHSRP delayed again

Senate Action on HB4070 (PHSRP) has been delayed again in Senate Appropriations Committee, where more than 100 proposed amendments await some kind of disposition. The huge rewriting of all public health and health professions' licensure laws into a single code has passed the house and been reported favorably by the Senate Committee on Health, Social Services and Retirement, but in the Senate Appropriations Committee "last chance" amendments have bogged down its progress. Meanwhile, the appropriations committee is turning most of its attention toward money bills and chances of early action on ment a hospital bed reduction system in Michigan, has been reported to the Senate floor with two amendments but probably will be put on the back burner until PHSRP emerges from appropriations committee scrutiny. HB4491 amends the Certificate of Need Act, which in turn is totally rewritten in HB4070, so the fate of the two bills are intertwined.

Michigan State Medical Society
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Managing Editor: Judith Marr

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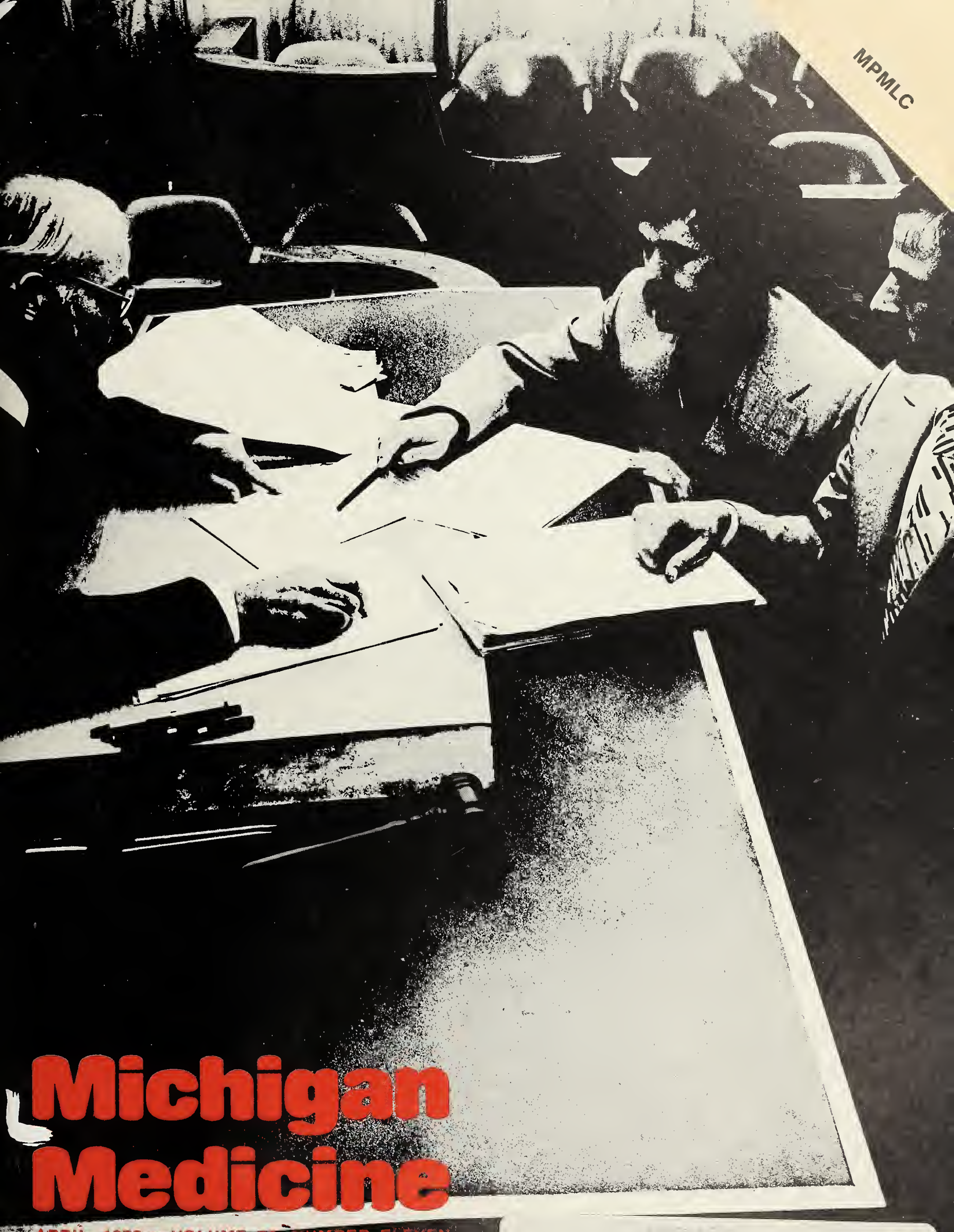
MPMLC



Michigan Medicine

APRIL, 1978 • VOLUME 77, NUMBER ELEVEN

JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

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Contents

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

BILL MITCHAM

The progress of the Michigan Physicians Mutual Liability Company, its affiliated state and national organizations, is reported in the special section, pages 183-186 in this issue.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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Michigan Physicians Mutual Liability Company strong and growing

By Suzanne Ludwig
Special to **Michigan Medicine**

Over the past two years, the Michigan Physicians Mutual Liability Company has evolved into a research-oriented firm seeking answers to thorny malpractice situations. Though a young company, the MPMLC is stongly situated on a firm foundation:

The company holds more than $6 million in surplus stock certificates.

More than 2,300 physicians are members and elect the 11-person physician governing board which sets company policies;

New doctors, setting up practice, receive a 50 percent discount during their first year of practice, an attraction drawing young, potentially long-term insureds. (Policies have been written for 150 such doctors in less than two years.)

Gathering Information

Less than three years ago, Michigan physicians faced the prospect of either paying greatly increased premiums to private insurers, or going without liability insurance. New doctors had no choice: In 1975 they were told flatly that they would not be insured against malpractice. At that time, only one private insurer was writing policies. Seven to 10 companies had left the arena because they viewed the medical liability field as a poor profit risk.

But now, MPMLC not only insures MD's and osteopathic physicians but is conducting research that can assist all doctors. It was obvious a few years ago the threat of malpractice claims formed a hedge between doctors and the public. The term "defensive medicine" became common in the early 1970's.

What was lacking, however, was hard data on claims: cost to the companies, what specialties and medical procedures were most likely to engender claims, etc.

A law passed in Michigan in 1975 required the opening of this information to which private insurers had previously been privy. Now, after almost two years of studying claims, the Michigan State Medical Society and the MPMLC have been able to take a statistical look at such claims. Moreover, the information is being studied by the MPMLC physician directors so that medical expertise can be brought to bear on it.

Setting up the company

When the company was approved by the Michigan Insurance Bureau in June 1976, it faced two immediate tasks:

1) Providing adequate insurance coverage to all qualified physicians at a premium price that was equitable but would assure corporate security;

2) Obtaining and examining information that would help ease the malpractice situation, on a short- and long-term basis.

Originally eight classes of insurance, based on specialty, offered rate structures according to liability category. Recently, a ninth category was added to refine the existing surgical coverage.

Rates also were determined by two geographic zones, the urban Wayne-Oakland-Macomb County area, and the remainder of Michigan. Current rates range from an $1,100 premium for a rural general practitioner to the urban surgeon's $16,000 premium.

Adjustments in rates are made for private practice physicians working less than 16 hours a week (private companies had been charging the full rate, even for semi-retired doctors). Part-time emergency room physicians are rated on non-emergency room practice if they also are insured by the hospital carriers.

Unlike the state-managed Brown McNeely Fund which must insure all applicants, MPMLC can refuse to write policies. However, less than one percent of the applicants have been refused coverage upon review of the MPMLC physician-based underwriters committee. A dissatisfied applicant may bring his case before a four-person board of appeal. He communicates with them in a peer setting in which constructive comment is offered by the committee.

A carefully defined surcharge system can be used for several reasons, from poor record keeping to practicing beyond the level of competence to recently alleviated alcohol or drug abuse. Such surcharges enable physicians to continue coverage while personal or professional problems are being worked out.

Michigan Physicians Mutual Liability Company

Types of Coverage

Currently two coverage rates are available to participants, a $100/$300,000 amount ($100,000 per incident and $300,000 aggregate) and a $200/$600,000 thousand coverage.

Current Priorities

William Cheeseman, president of Stratton-Cheeseman Management Company, Inc., which performs the day-to-day operations of MPMLC, suggests risk management is the biggest problem to be faced in the medical liability area. He is hopeful about the future of physician-owned liability insurance companies.

"Because physicians are involved in the studies, MPMLC is starting to see things about cardiac care, about anesthetics, problem drugs — even communications — that were not as visible before physician owned companies existed," Mr. Cheeseman points out.

"For example, if the company sees a certain anesthetic causing a disproportionate number of suits, it's going to study it. Or MPMLC sees a medical procedure that's causing a lot of problems, it will take a closer look.

MPMLC is excited about doing this. If the company can help physicians decrease certain errors, there will be direct financial benefits to the profession. We can see this as a trend in the next couple of years."

The MPMLC is surveying Michigan medical schools to see how the area of risk management is being presented to students. It also is studying use of consent forms, which would not be intended to replace personal contact, Mr. Cheeseman emphasizes, but to strengthen it. A primary asset of such forms is they can be used as an outline to review salient points important to the patient.

"We aren't talking about altering the practice of medicine," says Mr. Cheeseman. "Most of the meaningful risk management work will be in the areas of business practices and communication."

"During the next couple of years, we can see good information and sharing through the PIAA (Physicians Insurance Association of America.) Currently 17 member companies are functioning in almost as many states."

It is hoped such activity will alter the liability insurance picture. Rather than using punitive measures, the physician-owned companies such as MPMLC hope to offer positive incentives to help doctors function both as healers and as business people, two skills which are not mutually exclusive of each other.

Mr. Cheeseman

Pointing out many physicians are extremely busy, Mr. Cheeseman suggests in the future an insurance incentive might even induce some doctors to set more realistic limits on their practice.

The fact possible trouble areas can be wrestled with in terms of insurance coverage indicates the progress made in the last three years. In 1975, private companies lumped professional liability suits for all professions into one category, with no concerted effort to study causes of malpractice claims.

Now the 17 physician-owned companies in the U.S. have hacked their way through the thorny underbrush of statistics so that the garden is visible, weeds and all. The pruning and planting process seems to be in full swing, and an improved setting for doctor and patient is emerging.

UNIFORM DATA REPORT
PHYSICIAN-OWNED/MEDICAL SOCIETY-CREATED LIABILITY INSURANCE COMPANIES
NOVEMBER 1977

COMPANY	*POLICY HOLDERS*	*PROJECTED 12/31/77*	*MAXIMUM LIMITS*	*TOC*	*PREMIUM RANGE*	*AVERAGE PREMIUM*	*CAPITAL & SURPLUS*
ALABAMA	2,400	2,500	1M/1M	CM 0	952-3444 1568-7517	3100	8,000,000
ARIZONA	2,450	2,500	100/300	CM	1100-6900	3000	7,000,000
MIEC	2,200	2,500	2M/4M	CM (modified)	3000-19,000	5000	8,000,000
NORCAL MUTUAL	3,800	4,100	2M/4M	CM	1376-27,576	7900	18,000,000
SCPIE	3,300	3,500	1M/3M	CM	1880-15,980	6800	14,400,000
FLORIDA	5,333	5,000	1M/3M	CM	1384-16,825	5286	7,000,000
ILLINOIS	7,800	8,100	1M/1M	0	1292-17,200	5100	21,000,000
MARYLAND	3,920	3,950	1M/3M	0	909-8729	3104	3,000,000
MICHIGAN	2,376	—	200/600	0	100/300 1,112-16,000 200/600 1,390/20,000	5,300	6,821,000
NEW JERSEY	5,000	5,250	1M/3M	0	1388-17,412	5200	20,000,000
NEW MEXICO	875	900	100/300	0	1199-7118	2400	2,600,000
NEW YORK	17,312	17,600	1M/3M	0	563-22,981	5776	31,400,000
N. CAROLINA	3,550	3,800	2M/2M 1M/1M	CM 0	115-2349 774-9677	985	1,150,000
OHIO	2,600	2,800	200/600	0	1442-11,885	4522	8,000,000
TENNESSEE	4,300	4,450	1M/3M	CM	406-10,779	2247	5,900,000
TOTALS	67,095	69,250					

Data Collected Through American Medical Assurance Company

AMACO reports new activities by other state medical societies

The above chart describes the growing amount of activity in the professional liability insurance field by insurance firms started by state medical societies.

This information is from the American Medical Assurance Company, which was incorporated under the laws of the State of Illinois in 1975, and began doing business in June, 1976. AMACO, authorized by action of the AMA House of Delegates, is a wholly owned subsidiary of the AMA with capital and surplus of $5.1 million. AMACO deals exclusively in reinsurance for approved physician owned/medical society created insurance companies. It serves as a catalyst to reinsurance programs for companies desiring assistance by underwriting a portion of their reinsurance contracts. AMACO presently is providing a portion of the reinsurance for nine approved companies.

Richard G. Layton is the vice president-general manager of AMACO, and James H. Sammons, MD, is the president.

Mr. Layton reports the following activities from states that are not included in the above chart:

The Missouri Medical Fraternal and Educational Society, Inc., has initial capital of $1,000,000 and commenced business in December, 1977. They are offering both claims made and occurrence with limits of $1M/1M. Premium ranges are $195 to $1163 for claims made and $847 to $6486 for occurrence.

The Missouri Medical Insurance Company, wholly owned by the Missouri State Medical Association, is capitalized with $2.5 million. They are offering occurrence coverage with limits of $500,000/$1M.

The Pennsylvania Medical Society Liability Insurance Company was organized the first of this year following settlement of a dispute with Argonaut. Under the terms, Argonaut chose to terminate operations in Pennsylvania. The company is offering $100,000/300,000 limits for both claims made and occurrence. Occurrence premiums range from $1108 to $12,500 and the average premium is about $6800. They have about 4200 policy holders. Capital and surplus is listed at $6.5 million.

Elsewhere, Maine has voted to establish a company which should be operational within the next month or so. Johnson and Higgins out of Boston will be the managing company. Texas and South Carolina are conducting feasibility studies.

National association joins MPMLC with other physician-owned companies

With the formation of Michigan Physicians Mutual Liability Company and other like companies in many states, the need arose for a vehicle to provide for sharing information and experiences. Thus the Physician Insurers Association of America was conceived and organized in December of 1977.

PIAA is a coalition of physician owned insurance companies, those companies organized expressly to provide professional liability insurance for physicians. Affiliation with the American Medical Association, or a state or local medical society is a criterion for membership.

Incorporated in the State of New Jersey, the PIAA has a seven-man board of trustees comprised of physicians, and association and insurance executives. William B. Cheeseman, whose East Lansing-based Stratton-Cheeseman Management Company performs the day-to-day operations for MPMLC, is a member of this board, and the chairman of the PIAA Activities Committee.

The Activities Committee was charged by the board with developing the goals of the organization and the ways to carry them out. The committee envisions such activities as sharing policy forms and informed consent forms; sharing underwriting techniques, claims experience and data, and risk management information. In this regard they are developing an educational program to be presented in conjunction with the June AMA meeting in St. Louis. Additionally, at their March meeting in Chicago, five sub-committees were formed to facilitate development of further methods to get their programs underway.

Two other committees were named at the same time as the activities committee. One, the Bylaws Committee, has just completed its initial project to draft and distribute the bylaws. The other, the Finance Committee, worked out an equitable assessment of five cents per insured physician to provide initial operating funds for the organization. This was not intended to be precedent setting; a philosophy regarding dues and a formula for a dues structure is the current project of this committee.

The 15 physician-owned companies represented at the organizational meeting of PIAA in December, in turn represent 42 percent of the insured physicians in the nation. The feeling pervades that this Association, physician-oriented and looking at problems from the physicians' standpoint, appears to have an excellent chance of making its programs effective because of physician input and physician communications.

Malpractice Insurance
Pete Bentovoja

Times drawing by Pete Bentovoya

(This special section has been prepared in consultation with the MSMS Professional Liability Committee. Chairman is Robert M. Leitch, MD, Battle Creek. Members are Brock E. Brush, MD, Detroit; John F. Fennessey, MD, Grosse Pointe; Oliver D. Grin, MD, Grand Rapids; Frederick V. Minkow, MD, Bloomfield Hills; Rhoda M. Powsner, MD, Ann Arbor, and Joseph A. Sentkeresty, MD, Grand Rapids.

'Nothing can bring you peace but the triumph of principle'

So fast my term has run!

After thousands of miles of air and land travel, numerous meetings, tons of paper — documents, letters sent and received, phone calls — urgent, informative and conference, I am more convinced than ever we physicians must unify. We have the tools — AMA, AMPAC, MDPAC, our county societies and hospital staffs. We have the welfare of our patients and country at stake and they trust us.

When Blue Cross/Blue Shield favors one group — patient or physician — at the expense of others we must say no! Enough is enough! Tough, capable bargainers of the unions must no be allowed to make the remainder of policyholders pay for their health insurance. Physicians and hospitals must resist rationing of care as a method of reducing costs. Everyone should pay for what they get.

Medical costs are rising. True! Advanced technology and physicians' abilities to perform great medical feats have contributed some. But general inflation, malpractice rates, salaries for our medical assistants — yes, everything from utilities, gas, automobiles to paper, stamps, and paper clips have increased in cost. You cannot pass all these expenses on to patients, so to earn a compensatory salary you have to increase costs and workload. In so doing, you strain your relationship with patients and your physical and mental breakdown is imminent.

At the 1978 AMA leadership conference, gentlemen from Great Britain, Australia, Canada and France taught me that you must not allow a third party to interject itself between you and your patient. You and your patient must decide care, methods and payment together.

AMA Resolution 64(I-77) resolved the AMA-opposed third-party differentiation between covered services provided by participating and non-participating physicians is discriminatory against physicians who do not have a separate, contractual relationship with the carrier and inhibits patients' free choice of physician.

MSMS has recommended you and your patient discuss and determine your fee for service. Don't let others bargain for your services. Unify to provide necessary medical care. Protect the citizen's desire for medical services he has willingness and ability to pay for; that's his choice. Eighty percent of Americans say they trust you! They want you. We shall not let them down.

I am reminded of our great American philosopher of 130 years ago, Ralph W. Emerson, who said in "Self Reliance," "God will not have his work made manifest by cowards. A man is relieved and gay when he has put his heart into his work and done his best;

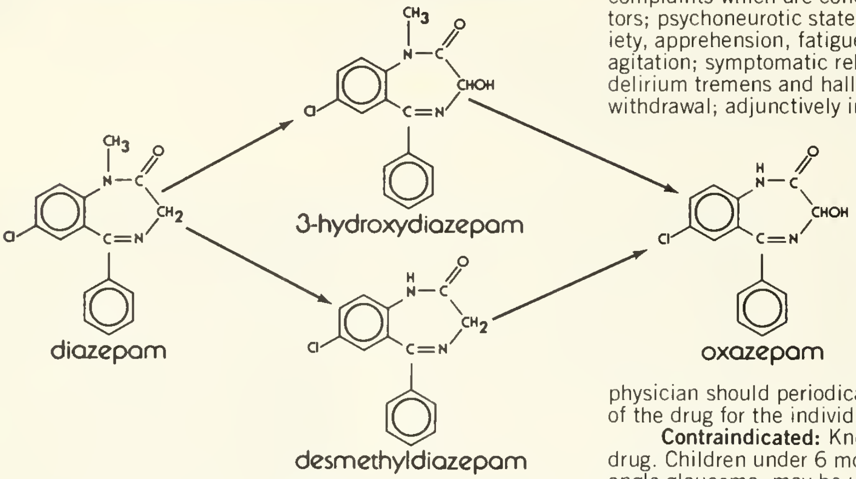
Vernon V. Bass, MD
MSMS president

"and we are now men, and must accept in the highest mind, the same, transcendent destiny; and not cowards fleeing before a resolution but guides, redeemers, and benefactors, obeying the Almighty effort; and advancing on Chaos and the Dark . . .

"Nothing can bring you peace but yourself. Nothing can bring you peace but the triumph of Principle."

It has been a joy to serve you. I thank you one and all. God bless.

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) Ⓘⓥ

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

For your information

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, a sampling of questions, with answers, are printed here. Subsequent issues will carry more.

FOR: Robert E. Rice, MD, Greenville, Chairman
Michigan Delegation to the AMA

"What is a good physician/population ratio?"

MSMS and AMA leaders feel strongly that any attempts to measure the adequacy of the distribution of physicians are virtually impossible — and always misleading. There are so many variables in determining peoples' access to physicians . . . such as highways, hospitals, medical schools, government medical agencies, medical residency programs, physician assistants, nurse practitioners, the age of the population. The AMA declares that "no commonly accepted standard exists that can be applied nationally." (A copy of the AMA statement regarding MD/population ratios and a list of references is available from Herb Auer at MSMS.)

Doctor Rice

FOR: Diane Place, FDA office
Detroit

"Didn't a judge in Oklahoma recently rule Laetrile can be dispensed in our country? What is the situation today?"

The FDA is appealing that decision, and expects a ruling in mid to late April. At present, Laetrile only can be purchased out of the country. The purchaser must get an affidavit from a physician indicating he is terminally ill with cancer, that a valid doctor-patient relationship exists, that further orthodox treatment would be fruitless, and indicating the patient has made a knowing choice to use Laetrile though informed by his physician that most cancer experts consider Laetrile worthless in combatting the disease. The affidavit affirms Laetrile will be used only in conjunction with established and recognized forms of cancer treatment and that it will be injected only under supervision of an MD.

The Oklahoma judge's decision prevents the FDA from interfering in the importation of Laetrile. The FDA appeal, on the basis that Laetrile is a new drug and has not been shown to be either safe or effective, is in the 10th District Court in Denver.

Ms. Place

(Editor's note: Physicians and other health professionals around the country are receiving letters from the National Cancer Institute requesting assistance in evaluation of Laetrile therapy. The NCI is seeking information on biopsy-proven cancer with objective evidence of anti-tumor response as documented by scans, X-rays, physical exams or other means during a period when the patient was treated only with Laetrile (with or without other metabolic therapy).

The information is being collected by the Laetrile Review Office, Office of Cancer Communications, National Institutes of Health, Bethesda, MD 20014.)

INFECTION!
-a "dirty" word to surgeons...

...'ANCEF' helps "clean up" the site

'ANCEF' Offers Broad Coverage

of major areas of postsurgical infection due to susceptible indicated organisms (See Brief Summary below).

High, Prolonged Serum Levels Mean

most infections can be treated with 500 mg to 1 gram every 8 hours.

Cefazolin Levels in Tissues and Fluids*

'Ancef' is present in bone, synovial fluid, skin and soft tissues (such as pleural fluid and lymph nodes).

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

Respiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus.*

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg, 500 mg, and 1 gram vials

Smith Kline &French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

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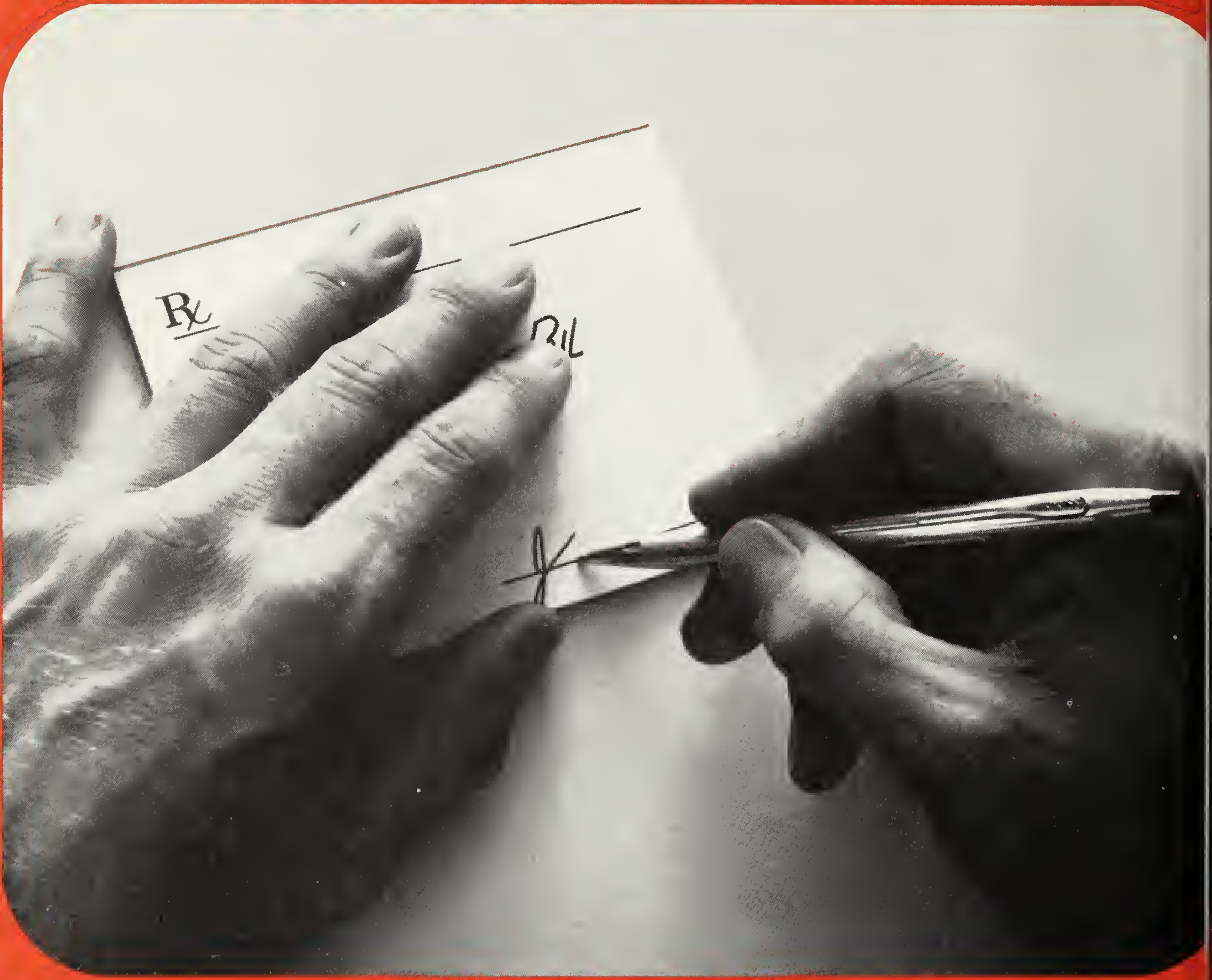
*Tissue penetration is regarded as essential to therapeutic efficacy; however, specific tissue levels have not been correlated with specific therapeutic results.

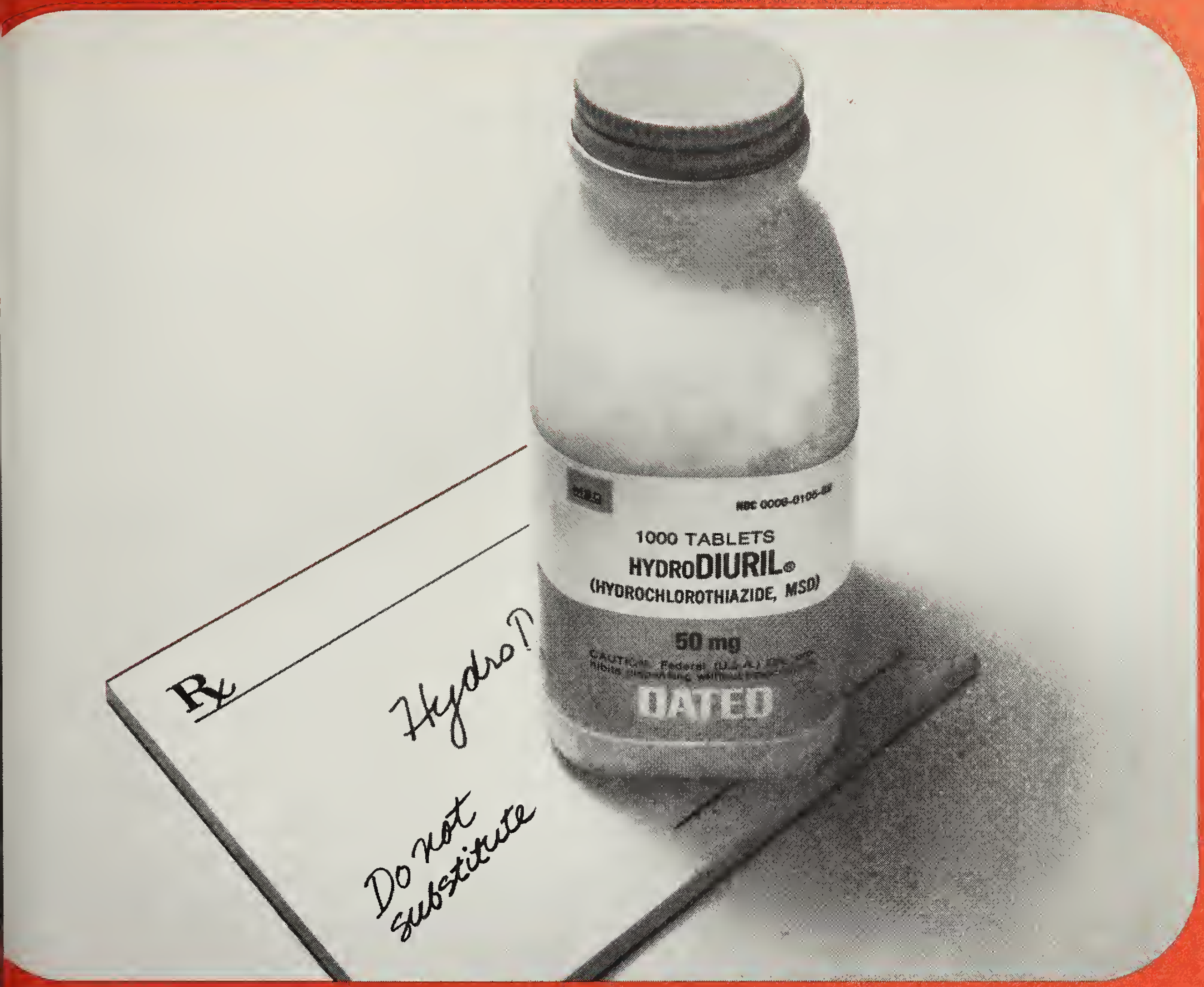
There is no substitute



yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.
Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.
Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective o cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotensior oliguria, tachycardia, and gastrointestinal disturbances such as naus and vomiting. Hypokalemia may develop, especially with brisk diure in severe cirrhosis, with concomitant corticosteroid or ACTH therapy with inadequate oral electrolyte intake. Hypokalemia can sensitize o exaggerate response of heart to toxic effects of digitalis (e.g., increas ventricular irritability). Hypokalemia may be avoided or treated by us of potassium supplements, such as foods with a high potassium con tent. Any chloride deficit is generally mild and usually does not requi specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, ap propriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certa patients. Insulin requirements in diabetic patients may be increased decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effective ness of the pressor agent for therapeutic use. If progressive renal im

or experience—



or ours.

nent becomes evident, consider withholding or discontinuing tic therapy. Thiazides may decrease serum PBI levels without s of thyroid disturbance. Calcium excretion is decreased by ides. Pathologic changes in the parathyroid gland with hyper-emia and hypophosphatemia have been observed in a few patients olonged therapy; thiazides should be discontinued before testing arathyroid function.

erse Reactions: *Gastrointestinal System*—Anorexia; gastric ir-on; nausea; vomiting; cramping; diarrhea; constipation; jaundice hepatic cholestatic jaundice); pancreatitis; sialadenitis.
ral Nervous System—Dizziness; vertigo; paresthesias; headache; nopsia.
atologic—Leukopenia; agranulocytosis; thrombocytopenia; stic anemia.
iovascular—Orthostatic hypotension (may be aggravated by nol, barbiturates, or narcotics).
ersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing tis (vasculitis) (cutaneous vasculitis); fever; respiratory distress ding pneumonitis; anaphylactic reactions.
r—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; kness; restlessness; transient blurred vision.
never adverse reactions are moderate or severe, thiazide dosage ld be reduced or therapy withdrawn.

e: When used with other antihypertensive drugs, careful observa- for changes in blood pressure must be made, especially during l therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

J6HD04(528)

MSD
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In hypertension

TABLETS: 25 mg, 50 mg, and 100 mg

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Category I courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Because of space limitations, it is not possible to list the many continuing courses and series sponsored by many hospitals and organizations in Michigan. Information about those possible programs may be obtained from the accredited sponsors.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351

Date: April 17-21, Cardiac Tutorial Program. Location: Henry Ford Hospital, 2799 W. Grand Blvd., Detroit. **Sponsor:** Henry Ford Hospital. **For:** General Practitioners, Internists. **Cost:** $250. **Contact:** Sidney Goldstein, MD, Head, Division of Cardiovascular Medicine, Henry Ford Hospital, 2799 W. Grand Boulevard, Detroit, 48202 (313) 876-2727. **Approved for:** 40 hours of Category I Credit.

Date: April 17-21, Family Practice Review II. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-sponsor:** Michigan Academy of Family Physicians. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 37 hours of Category I Credit.

Date: April 25, Continuing Pathology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 6½ hours of Category I Credit.

Date: April 25, Infectious Diseases Symposium. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Hospital. **Contact:** Butterworth Hospital, Medical Education Office, 616/774-1835. **Approved for:** 8 hours of Category I Credit.

Date: April 26, Infectious Diseases in Clinical Practice. Location: Southwest Detroit Hospital Inc. **Sponsor:** Department of Medical Education, Southwest Detroit Hospital. **For:** All specialties. **Cost:** $35. **Contact:** Oswald Bostic, MD, Director, Medical Education, Southwest Detroit Hospital, 2401 20th St., Detroit 48216. **Approved for:** 8 hours of Category I Credit.

Date: April 26, Second Annual Pediatric Orthopedic Clinic Day. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** Detroit Orthopedic Clinic and Children's Hospital of Michigan. **Co-sponsor:** Wayne State University School of Medicine. **For:** All specialties. **Cost:** None. **Contact:** Richard LaMont, MD, Chief, Dept. of Orthopedic Surgery, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, 48201, 313/494-5581. **Approved for:** 6 hours of Category I Credit.

Date: April 28-29 Upper Peninsula Medical Society Annual Meeting. Location: Terrace Motor Inn, Escanaba. **Sponsor:** Upper Peninsula Medical Society. **Co-sponsor:** Michigan State Medical Society. **For:** All specialties. **Cost:** $15. **Contact:** A. Leslie Rose, MD, Doctor's Park, Escanaba, MI 49829 (906) 786-4628. **Approved for:** 9 hours of Category I Credit.

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City State Hospital Traverse City
V.A. Hospital, Battle Creek
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: **May 3, 10 and 17, The Family Practitioner and Psychiatry. Location:** E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital. **Cost:** None. **Contact:** R. W. Pomeroy, MD, E. W. Sparrow Hospital.*** **Approved for:** 3 hours of Category I Credit.

Date: **May 4-5, The High-Risk Infant. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $75. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 12 hours of Category I Credit.

Date: **May 6, Hurley Medical Center Regional Oncology Symposium. Location:** Hurley Medical Center, Flint. **Sponsor:** Hurley Medical Center. **For:** All specialties. **Contact:** Richard D. Garlick, Director, Continuing Medical Education, Hurley Medical Center, Sixth Avenue and Begole St., Flint 48502. **Approved for:** 6 hours of Category I Credit.

Date: **May 6, Alcoholism: Special problems and techniques in working with families in which alcohol is a problem. Location:** Ramada Inn, Lansing. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** 313/545-1144 or 313/662-2330. **Approved for:** 3 hours of Category I Credit.

Date: **May 9-10, InterQual's Concurrent Review Seminar. Location:** Hilton Inn Lansing/7501 West Saginaw Highway/Lansing, 48917 (517)627-3211. **Sponsor:** Endorsed by: Michigan Region VI PSRO, East Lansing; Western Michigan PSRO, Inc., Grand Rapids; Area VII PSRO, Ann Arbor. **For:** Medical Staff Members, UR Physicians, Administrators, Review Coordinators, Social Workers, All other hospital personnel. **Cost:** $130. **Contact:** Monica Eckart, Seminar Registrar, InterQual, 740 N. Rush St., Chicago, 60611. (Telephone registrations accepted, toll-free (800)621-6109; IL (312)751-2327.) **Approved for:** 8 hours of AMA Category I Credit and 10 hours American Medical Records Association.

Date: **May 10, 18th Annual Spring Clinical Conference, "Practical Management of Cerebral Vascular Disease." Location:** Kalamazoo Center, 100 West Michigan, Kalamazoo, Michigan 49006. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians. Internists, Neurosurgeons, General Practice, Emergency Medicine, Neurologists. **Cost:** $40. **Contact:** Charles L. Zeller, Jr., M.D., % SMAHEC, 252 East Lovell, Kalamazoo, Michigan 49006. **Approved for:** 7 hours of Category I Credit.

Date: **May 10, Cancer Update. Location:** Gordon Scott Hall, WSU. **Sponsor:** WSU Department of Oncology. **Cost:** $25. **Contact:** Ms. Jeanette Radman, Department of Oncology, WSU School of Medicine, Scott Hall of Basic Medical Sciences, 540 E. Canfield Ave., Detroit, 48201. **Approved for:** 6 hours of Category I Credit.

Date: **May 10-12, 21st Annual Clinic Days, "Orientation to Adolescent Care." Location:** Children's Hospital of Michigan, Detroit. **Sponsor:** Department of Pediatrics and Department of Surgery, Children's Hospital of Michigan. **Cosponsor:** Wayne State University School of Medicine. **For:** All specialties. **Cost:** $125. **Contact:** Community Relations, CHM, 3901 Beaubien Blvd., Detroit, MI 48201, 313/494-5373. **Approved for:** 18 hours of Category I Credit.

(Continued on page 196)

Letters

More details on Blues lawsuits

In a recent issue of the *Medigram*, the Michigan State Medical Society (MSMS) newsletter, under the heading of "A chronological backgrounder on Blues talks of past weeks," the editor of that newsletter presented a progress report of the negotiations with Blue Cross/Blue Shield of Michigan (BCBSM) and the legal actions against BCBSM that have been initiated by the law firm of Kerr, Wattles, and Russell on behalf of the otolaryngologists and the Michigan Psychiatric Society (MPS).

The documentation of events as described in that report did not mention the temporary restraining order issued by Judge Irwin H. Burdick of the Wayne County Circuit Court. This must have been an oversight, since many of us have been aware of the TRO through the coverage it received in the news media. Therefore, the progress report does not reflect all the pressure that is being brought to bear upon BCBSM by all responsible and concerned physicians in Michigan. Greater detail is available from our committee to all interested physicians.

Sheldon N. Siegel, MD
Committee on
Concerned Psychiatrists
Livonia

Physicians' incomes from 1970-74, not 1977

A feature article entitled "Physicians Incomes Increasing Slower Than Most" (*Michigan Medicine*, January 1978) has recently come to my attention. The physician income figures that were cited in the article have been erroneously attributed to the volume *Profile of Medical Practice, 1977* under my editorship. As shown on the attached table copied from the *1977 Profile*, the income physicians presented are for the years 1970 to 1974. The 1975 and 1976 AMA physician income figures will not be available until the publication of the *1978 Profile* in June of this year.

Sincerely,

Sharon R. Henderson
Research Associate
AMA Center for Health Services
Research and Development

(Editor's note: *The first figure ($34,740 average income in 1967) was from* Rising Medical Costs in Michigan: The Scope of the Problem and the Effectiveness of Current Controls, *a report of the* Technical Work Group on Health Care Costs, *published by the Michigan Department of Social Services in 1973. The 1975 figure ($53,600) should have been cited as from the* American Medical News, *August 1, 1977.)*

Appreciation for journal article

I would like to express to you our appreciation for the article in the journal "Here's definitive description of disability determination system," pg 118, February 1978 *Michigan Medicine*. It was presented in such a way that I feel sure the picture should be quite clear to any reader. It will certainly alleviate a lot of misunderstanding by the practicing physician concerning our agency and what we are trying to do for the people of Michigan in relation to the determination of disability. One never knows who might be next when applications are made — we have had our share of adjudications on physician applicants as well as all others.

Sincerely,

Harry D. Nesmith, MD
Chief Medical Consultant
Disability Determination Program
Vocational Rehabilitation Service
Michigan Department of Education

CATEGORY I COURSES/*continued*

May 11, 12, Heart Days, "Heart and Stroke Dialogue: Congroversy and New Models." Location: Hyatt Regency Dearborn. **Sponsor:** Michigan Heart Association. **For:** All specialties. **Cost:** $50. **Contact:** Michigan Heart Association, P.O. Box LV-160, Southfield, 48076, 313-557-9500. **Approved for:** 9 hours of Category I Credit.

Date: May 12, 13, Conference for Physicians — "What Do You Say When Your Patient Asks About Nutrition?" Location: Lansing Hilton Inn. **Sponsors:** Dairy Council of Michigan; MSU Departments of Food Science and Human Nutrition, College of Human Medicine and College of Osteopathic Medicine. **For:** All interested physicians. **Cost:** $60 for physicians; $25 for residents; $10 for students. **Contact:** Dairy Council of Michigan, 313/875-3162. **Approved for:** 9 hours of Category I Credit.

Date: May 13, Oncology-Hematology Conference. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital, Continuing Medical Education Department. **For:** Primary care physicians, internists. **Cost:** $60. **Contact:** HFH Medical Education Office, 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: May 13, Michigan Society of Pathologists May Seminar. Location: Michigan State University, East Lansing. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: May 15-19, Head and Neck Oncology. Location: University of Michigan, Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **For:** All specialties. **Cost:** $350 for physicians-in-training, $500 for practicing physicians. **Contact:** U-M Office of PGM/HPE. **Approved for:** 42½ hours of Category I Credit.

Date: May 15-19, Head and Neck Oncology. Location: Towsley Center for Continuing Medical Education, University of Michigan, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Cost:** $500 for practicing physicians, $350 for physicians-in-training. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 42½ hours of Category I Credit.

Date: May 16, Continuing Pathology Conference. Location: The Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor, Michigan. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD.* **Approved for:** 6 hours of Category I Credit.

Date: May 17, "Medical Ambiguities in Medical Decision-Making." Location: Borgess Hospital Auditorium, 1521 Gull Road, Kalamazoo, 49001. **Sponsor:** Borgess Hospital. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** All specialties. **Cost:** $20. **Contact:** Robert Warnke, MD, 1634 Gull Road, 101 - Kalamazoo Medical Arts, Kalamazoo, 49001. **Approved for:** 7 hours of Category I Credit.

Date: May 17, "Diabetes Mellitus — 1978." Location: Hilton Inn, Lansing. **Sponsor:** Capital Chapter, Michigan Division of American Academy of Family Physicians. **Co-sponsor:** Michigan State Medical Society. **For:** Internal Medicine and Family Practice. **Cost:** $25. **Contact:** Richard L. Hatton, MD, 2321 Indian Hills Drive, Okemos, 48864. **Approved for:** 8 hours of Category I Credit.

Date: May 18-19, Third Annual Course in Forensic Pathology. Location: Radisson Cadillac Hotel, Detroit. **Sponsor:** Wayne State University School of Medicine and Wayne County Medical Examiner's Office. **For:** Pathologists. **Cost:** $80. **Contact:** Werner U. Spitz, MD, Chief Medical Examiner, 400 E. Lafayette Avenue, Detroit, 48226, 313/224-5648. **Approved for:** 12 hours of Category I Credit.

Date: May 19-20, Nuclear Radiology Workshop. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** U-M Office of Postgraduate Medicine and Health Professions Education. **For:** All specialties. **Cost:** $140. **Contact:** U-M Office of Intramural Education.* **Approved for:** 16½ hours of Category I Credit.

Date: May 20, Care of the Injured Hand. Location: Detroit Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** American Association for Hand Surgery; Michigan Academy of Plastic Surgeons. **For:** All specialties. **Cost:** $60. **Contact:** Kim K. Lie, MD, 27500 Hoover Road, Warren, 48093. **Approved for:** 7 hours of Category I Credit.

Date: May 21-23, Symposium on Environmental Carcinogenesis. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** Michigan State University College of Human Medicine, College of Osteopathic Medicine, College of Veterinary Medicine, Basic Science Cancer Research Group and the Michigan State University Foundation in cooperation with Continuing Education Service. **For:** All specialties. **Cost:** $18, $6 for students. **Contact:** Kellogg Center for Continuing Education, MSU, East Lansing, 48824. **Approved for:** 15 hours of Category I Credit.

Date: May 22-26, Internal Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $250. **Contact:** Floyd C. Pennington PhD, U-M Office of Intramural Education.* **Approved for:** 33½ hours of Category I Credit.

Date: June 1-2, Preventive Health Care for the Elderly. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 11 hours of Category I Credit.

Date: June 3, Cultural Differences: The implication for treatment of cultural and ethnic differences among families and between family and therapist. Location: Ramada Inn, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** 313/545-1144 or 313/662-2330. **Approved for:** 3 hours of Category I Credit.

Date: June 5-9, Psychology of Aging. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 30 hours of Category I Credit.

Date: June 5-16, Biology of Aging. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, MI 48109. **Approved for:** 30 hours of Category I Credit.

Date: June 7, 14 and 21, Gastroenterology/Family Practice. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital. **Cost:** None. **Contact:** R. W. Pomeroy, MD, E. W. Sparrow Hospital.*** **Approved for:** 3 hours of Category I Credit.

Date: June 22-24, Keyport-Gaylord Trauma Symposium. Location: Gaylord. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $25. **Contact:** Wayne State University, Division of CME,** or Benjamin E. Henig, MD, 308 Michigan Ave. Grayling, 49738. **Approved for:** 12 hours of Category I Credit.

Date: June 25-30, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $200. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21½ hours of Category ICredit.

Date: June 29-30, Mental Health in Aging. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology and U-M Medical School. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, University of Michigan, 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

Date: July 27-28, 1978 Coller-Penberthy-Thirlby Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center, Traverse City. **For:** All specialties. **Cost:** $25. **Contact:** Thomas Auer, MD, % Munson Medical Center, Traverse City, MI 49684. **Approved for:** 9 hours of Category I Credit.

Date: July 31-August 4, and November 6-10, Principles of Milieu Practice: Working with the Elderly in Treatment Settings. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 35 hours of Category I Credit.

Date: Sept. 13, Third Annual Renal Disease Conference. Location: Kalamazoo Center, 100 West Michigan, Kalamazoo, Michigan 49006. **Sponsor:** Michigan Nephrology Center. **Cosponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians, Internists, General Practice, Nephrologists. **Cost:** $35. **Contact:** Jeffrey Block, M.D., Michigan Nephrology Center, 1521 Gull Road, Kalamazoo, Michigan 49001. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 28-29, Coping with Changes in the Later Years. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

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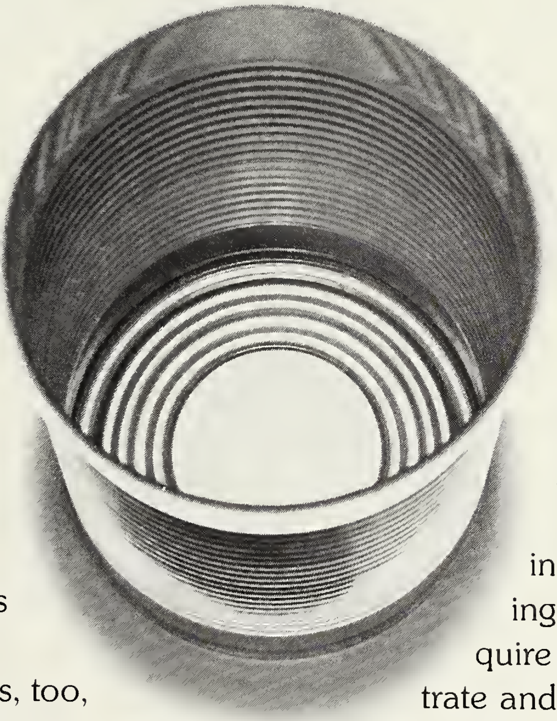
*Office of Intramural Education, University of Michigan Medical Center, Dep't of PBM/HPE, Ann Arbor, 48109.

**WSU Division of CME, Room 1206, Scott Hall, 540 E. Canfield, Detroit, 48201 (313)577-1180.

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

NOW a two-piece 14 oz. can for Soyalac



A two-piece can means no soldered seam. No solder means no possibility of lead contamination from the container. Soyalac is the first infant formula with this packaging innovation.

There are improvements, too, in the formulation. Soyalac now has 25% more iron than known competitive hypoallergenic milk-free formulae. In fact, the entire formula has been slightly modified to reflect the current U.S. RDA levels set by the Food and Drug Administration.

Soyalac — formula for infants on regular feeding and for those who require milk-free diets; concentrate and single strength, ready-to-use. Made from the whole soybean. I-Soyalac concentrate, made from soy isolate, with no soy carbohydrates and **no corn products.**

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• MILK-FREE FORTIFIED INFANT SOY FORMULA
READY TO SERVE
NET WT 14 FL. OZ., 414 Ml
Loma Linda
i-soyalac
CONCENTRATED LIQUID - add water
NET WT 14 fl oz, 414 ml

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Medicaid Liaison Committee works for Michigan MDs

The MSMS Medicaid Liaison Committee continues its dialogue with officials from the Michigan Department of Social Services, Michigan Department of Public Health, and Office of Health and Medical Affairs. At its most recent meeting the committee and state officials discussed several subjects of concern to physicians. Items on the agenda were 1978-79 appropriations for physician services under Medicaid, the reimbursement policies for physician assistant services, the proposed consolidation of all Medicaid services under the single agency (MDSS), a review of the reimbursement policies for consultative services rendered by family physicians, and the newly-authorized regulations on sterilizations.

Participating in the Liaison Committee discussions are (from left to right) Paul M. Allen and Robert C. Bonhag of the Michigan Department of Social Services, John W. Coles, MD, of Mt. Pleasant, and Jay C. Endsley of the Office of Health & Medical Affairs.

Michigan Department of Social Services Director John T. Dempsey, PhD, (right) refers to his notes as he apprises the committee of the proposed plans for consolidation of Medicaid services under MDSS. Medicaid Liaison Committee Chairman David Siegel, MD, (left) listens attentively.

Maurice S. Riezen, MD, Director of the Michigan Department of Public Health, (left) personally attends the quarterly meetings of the Medicaid Liaison Committee, to speak to the concerns of MDPH. MSMS President-Elect Louis E. Heideman, MD, (right) plans to observe the deliberations of all MSMS committee meetings and chose this joint session between MSMS and representatives from the MDSS, MDPH, and OHMA as one of the first on his itinerary.

COLACE prevents hard, dry stools common to constipation . . . and does it without laxative stimulation. COLACE assists peristalsis by simply letting intestinal water permeate stools.

COLACE helps to prevent painful straining at stool—particularly important in patients with delicate anorectal disorders. Safe and non-habit forming . . . COLACE, the simple water way to ease constipation from infancy to old age.

Simple drops of water help make COLACE® the most widely used stool softener.

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COMPATIBILITY

Eastern Tiger Swallowtail Butterfly
(Papilio glaucus)

Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan–compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

MeadJohnson
PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his next breath...

he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

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PHARMACEUTICAL DIVISION

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1878 *Michigan Medical News* strove to be 'live, practical journal'

By Mary Ann Butt
Special Feature Writer

Costs for Michigan residents to attend medical school at the University of Michigan total $40. That's for a nine month session, according to the January 21 issue of *Michigan Medical News* — Jan. 21, 1878, that is.

The University also offers, in the same issue, a "course separate, but equal, for women."

The purpose of the *Michigan Medical News*, a semi-monthly Detroit-published journal, was "to supply the want which exists for a live, practical journal which shall pay special attention to therapeutics and items of medical news, which can be furnished at a price which places it in the power of all to subscribe for it, and which shall be issued sufficiently often for the wants of the busy practitioners."

Formulae for maladies

The old journals are abundant with doctors' own formulae for all types of maladies:

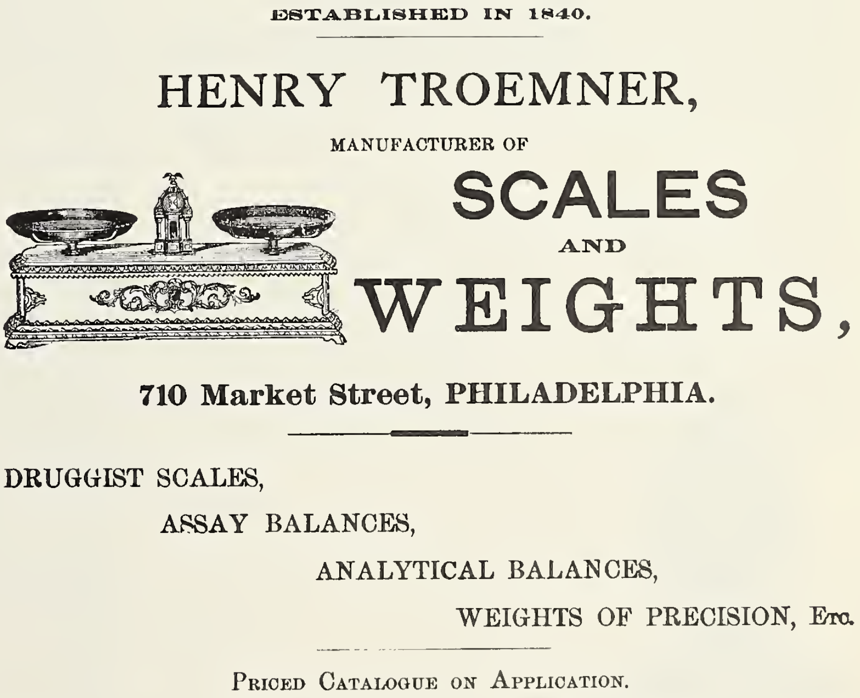
— A recipe for "Powder for Sweating Feet" says to mix "salicylic acid, alum, wheat starch, oil of bergamot and alcohol" and then add Venetian talc.

— An "old fashioned tonic and diuretic" calls for "digitalis leaves, parsley roots, horse radish, mustard seed, quill, juniper berries, cream of tartar, subcarb iron, and hard cider." The instructions say to mix these ingredients, and "let the mixture steam by the fire all day in a stone jug. Sig. — Wineglassful three or four times a day."

— One physician claimed to have a cure for epilepsy — even for cases of long standing. According to an item in the Nov. 10, 1878 issue, this physician "employs a solution of seven grains of curare in seventy-five minims of water, to which he adds two drops of hydrochloric acid. At intervals of about one week he injects, hypodermically, eight drops of this solution, and, in cases in which convulsions had occurred for several years, he obtained a complete cure after eight or ten injections."

— Formulae for "Gentian and Rhubarb Draught" and "Alkaline Colombo Draught," according to a Doctor T. Launder Brunton of St. Bartholomew Hospital's pharmacopoeia, " 'work wonders' in cases of chronic gastric catarrh with flatulence — the 'windy spasms' of old women."

Other items found in the brittle pages of 100 years ago seem more sophisticated — as in a July 10, 1878 issue's article on the "wonderful recent invention, by Prof. Hughes" — the microphone. The article describes how Sir Henry Thompson had just put the microphone "to practical use, for the first time, in sounding for stone in the bladder." On the occasion of its recent trial, the article says, "it caused the note of contact with the calculus to be distinctly audible clear across an ordinary-sized bed chamber." The article says although the microphone is not a "medical toy," it remains merely a "resource which we have in reserve for exceptional and difficult cases, or for those who may find it perhaps more useful than their unassisted hands and ears."



ESTABLISHED IN 1840.

HENRY TROEMNER,

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710 Market Street, PHILADELPHIA.

DRUGGIST SCALES,

ASSAY BALANCES,

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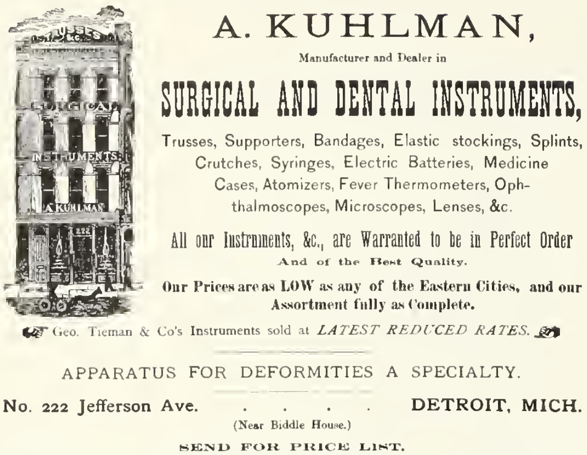
Priced Catalogue on Application.

This advertisement appeared in the Nov. 10, 1878 issue of *Michigan Medical News*.


TRUSSES &c.
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A. KUHLMAN,

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Trusses, Supporters, Bandages, Elastic stockings, Splints, Crutches, Syringes, Electric Batteries, Medicine Cases, Atomizers, Fever Thermometers, Ophthalmoscopes, Microscopes, Lenses, &c.

All our Instruments, &c., are Warranted to be in Perfect Order

And of the Best Quality.

Our Prices are as LOW as any of the Eastern Cities, and our Assortment fully as Complete.

☞ Geo. Tieman & Co's Instruments sold at *LATEST REDUCED RATES.* ☜

APPARATUS FOR DEFORMITIES A SPECIALTY.

No. 222 Jefferson Ave. . . . . . DETROIT, MICH.

(Near Biddle House.)

SEND FOR PRICE LIST.

Advertisement from Nov. 10, 1878 issue of *Michigan Medical News.*

Detroit scrupulously clean

Verbose editorials characterized most of the 1878 journals. In the July 25, 1878 issue the editorial is a response to an item in the *Pacific Medical and Surgical Journal* which said that many of San Francisco's physicians "complain that they have had less to do than for 15 or 20 years" because the population of that city was "exhibiting a degree of health quite remarkable." The editor of *Michigan Medical News* responds to this item by devoting his editorial to the subject of the healthy state of Detroit citizens. He attributes the healthy condition to Detroit's "broad, scrupulously clean" streets. He says the city is "well supplied with sewers and these are kept well washed out with an abundance of running water, which is emptied below the source of supply into the swift current of the Detroit river."

In fact, people in Detroit were so healthy that, according to the editorial, "a first class doctor may be had in this city for fifty cents per visit, and he will give his advice, with a prescription, for just half this amount."

What's a "first class doctor?" According to the 100-year-old editorial, he's one who is "a member of the American Medical Association, of the Michigan State Medical Society and of a local medical society."

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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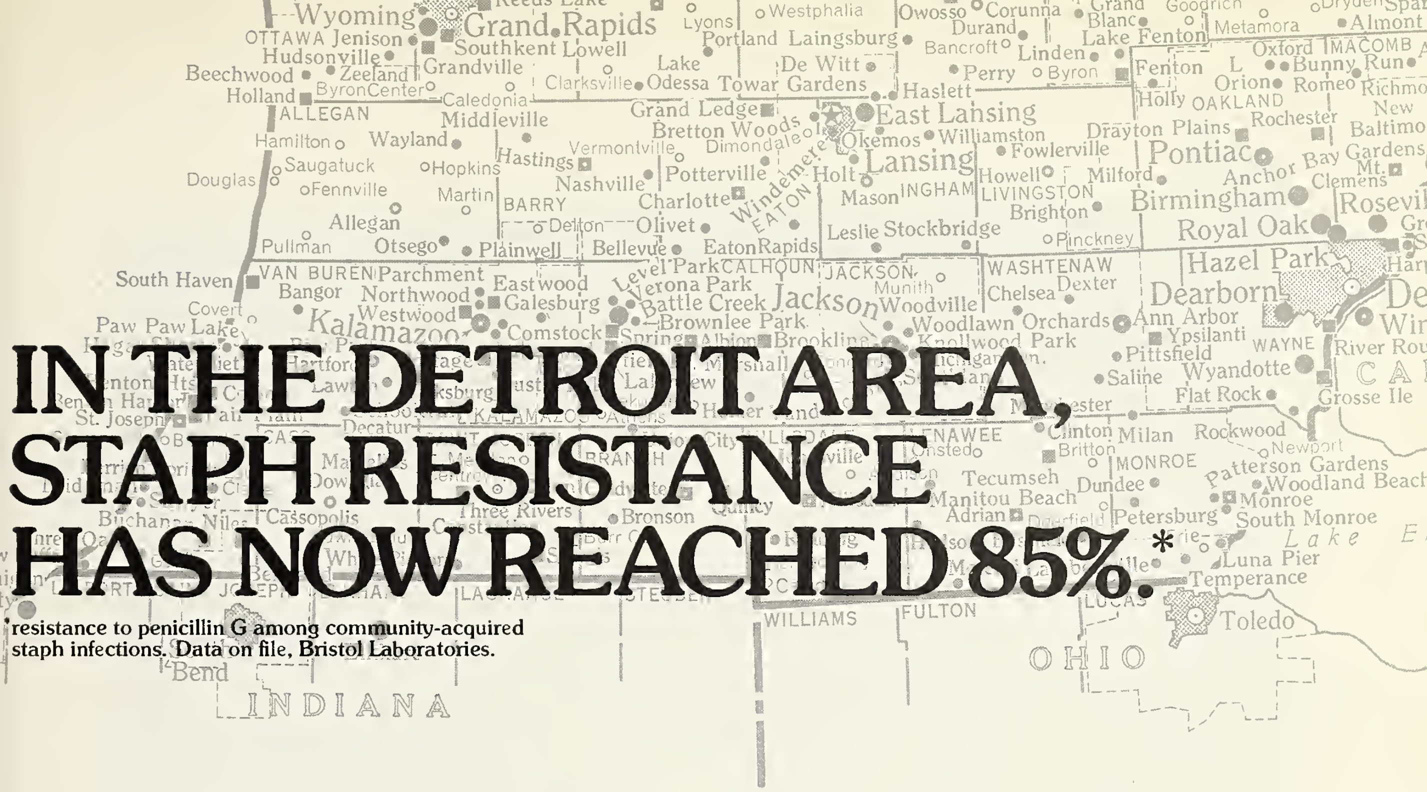
Syracuse, New York 13201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IN THE DETROIT AREA, STAPH RESISTANCE HAS NOW REACHED 85%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

TEGOPEN®

(cloxacillin sodium)

..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.

- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.

Please see brief summary
for prescribing information.

Liability

Dangers of dropping malpractice coverage

"Going bare" sounds like an intriguing way of avoiding high insurance premiums and registering a strong protest against the current malpractice situation. But is it practical? The answer is a resounding no.

While it is possible to drop insurance coverage and sign away your assets to an irrevocable trust, this will not necessarily protect you if you are sued for malpractice. The court could quickly negate the transfer if it determined that your action was taken solely to avoid the claim of a "creditor."

More importantly, any judgment against you is valid despite the fact that you have rendered yourself totally insolvent. This means future earnings could be attached and liens would be placed against future possessions. *You could be kept in a perpetual state of bankruptcy!*

"Going bare" also may jeopardize your hospital staff privileges. Any party to a lawsuit may be held liable for the entire award or settlement, so if a physician is not insured, the hospital could be assessed the full amount. As a result, many hospitals are requiring malpractice coverage as a condition of medical staff membership.

Another alternative to malpractice insurance that has gained some advocates is the "self-insured" concept. Under this system, the physician sets aside a certain amount each month to cover the cost of possible suits. Is *this* practical? Again, the answer is a resounding *no*.

The average cost of a malpractice trial can easily top $20,000. And if you lose the case, you will also be forced to pay an award. Even with a small award, total costs would be substantial.

If you set aside $10,000 annually under your self-insured program, one case could easily wipe out reserves accumulated over four or five years. A suit resulting in an astronomical award would spell certain disaster.

In addition, the long delay in reporting malpractice claims means you will be vulnerable to claims several years after retirement.

Malpractice insurance is expensive, but it's the only practical way to protect yourself against financial disaster in today's volatile malpractice climate.

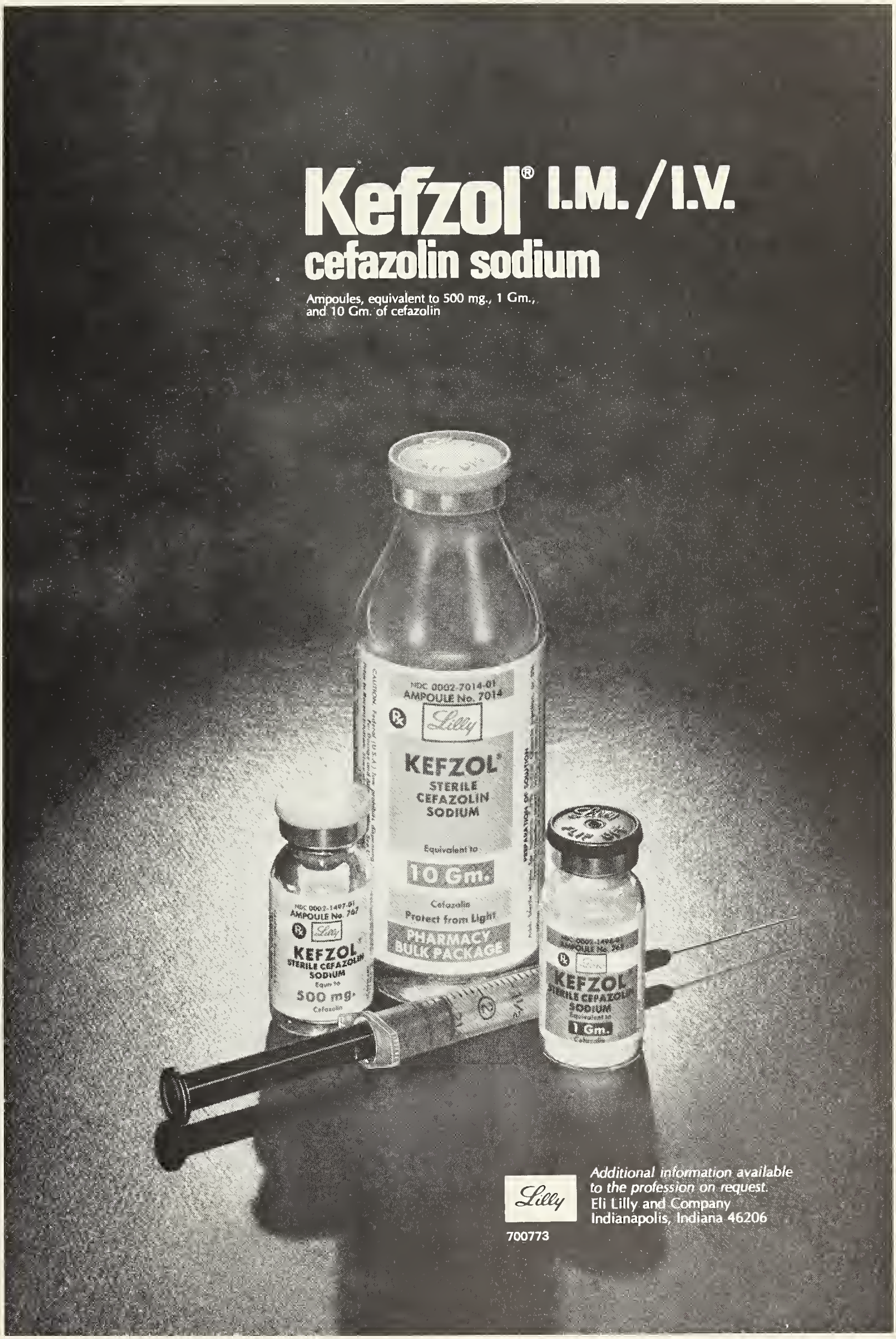
(This is the fifth in a series of articles on risk management to appear in Michigan Medicine. It is sponsored by the MSMS Committee on Professional Liability, chaired by Robert M. Leitch, MD, Battle Creek, MSMS immediate past president. The material was originated with the Illinois State Medical Society, which has prepared tape cassettes on the subject.)

This information is advisory only and is *not* intended to imply or establish a standard of care, or to substitute for advice of personal legal counsel.

Legal myths that persist

A. Stewart Kerr, MSMS legal counsel, offers a tongue-in-cheek list of some old myths that just won't die, but should:

- That if organized medicine would form into "unions" or "guilds," this would somehow (1) avoid antitrust problems and (2) give legal status to "negotiate" with third parties.
- That lawyers who try court cases against doctors are villains; that lawyers who defend doctors but suggest settlement also are villains.
- That significant numbers of informed consent cases are tried.
- That significant numbers of informed consent trials are lost.
- That every malpractice case should be tried to conclusion.
- That "going bare" is achieved without disruption to estate planning.
- That "going bare" will stop plaintiff attorneys in their tracks.
- That Michigan law requires staff privileges be granted to any licensed physician, if there are staff vacancies.
- That medical societies must accept every licensed applicant — and keep him.
- That any malpractice case, successfully defended, merits a counter-suit.
- That all malpractice suits are non-meritorious and/or nuisance suits.



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The latest on Michigan's arbitration system with typical questions answered

By Michael R. Arford
Detroit

The Michigan medical malpractice arbitration program was enacted into law in 1975 and implemented on January 1, 1976. Since that time many misconceptions, misunderstandings, and questions have arisen. This article addresses those that are most often heard.

Q. Won't the presentation of an arbitration agreement to every patient result in an increase in claims being filed?

A. No. Studies of similar arbitration programs in force at the Ross-Loos Medical Group in Los Angeles since 1929, and utilized by the Southern California Hospital Arbitration Project since 1969 demonstrate this very common concern has no basis in fact. In fact, many California hospitals have experienced a drop in claims since the introduction of arbitration.

To date, Michigan interim studies have not had enough time to yield data to support the proliferation of claims theory. But available information indicates that after two years of the program, this fear is unwarranted.

Q. Doesn't the provision allowing the patient to revoke the agreement within 60 days, while the hospital and physician cannot, give the patient all the options?

A. No. This provision recognizes that some patients will sign any forms offered them in a hospital or doctor's office, even though they may not fully understand them. Some patients fear failure to sign may result in withholding of needed treatment.

The revocation provision gives the patient the same opportunity doctors have to make or review their decision when emotion is not a controlling factor and when they are in possession of full information. This provision, together with other requirements of the law, permits a court to uphold the validity of the agreement in cases where the voluntary quality of the patients' assent to arbitration is questioned.

Q. Is it true that patients do not want arbitration and are not signing the agreements?

A. No. Although state-wide statistics are not yet available, limited reports have shown that between 60 percent and 80 percent of patients who are offered the arbitration option elect to sign it. These figures probably do not even fully represent the percentage of patients who favor the arbitration process.

There is increasing evidence many patients who actually have made no real decision either way are counted, because of current reporting methods, as having declined.

It also has become apparent that the percentage of patients signing the option is a direct function of how well the option is offered. In hospitals where the option is offered in a neutral manner and in such a way that the patient understands it and has an opportunity to make an informed decision, the vast majority do sign it.

Q. If the patient signs the agreement, does not revoke it within 60 days, and subsequently wants to file a claim, can he still take the case to court?

A. No. If a valid arbitration agreement exists covering the incident in dispute and the patient has not revoked it within the alloted time, he no longer has a choice of forum. The agreement should be brought to the attention of the court where it can be enforced, so the case can be remanded to arbitration.

Q. Is it true if the patient does not like the arbitrators' decision, he or she can appeal to the courts?

A. No. Arbitration is not a preliminary step to court action. It is an alternative to it. Arbitration awards in these cases are final and binding. A court cannot grant a new trial to consider the merits of the award.

There is a limited right of appeal from arbitration awards; this right extends to all parties to an arbitration. While a court will not review the substance of the case on appeal, it may decide to overturn an arbitration award on procedural grounds, if a party can prove fraud, corruption, or misconduct by the arbitrators.

In the extremely rare instance where a court overturns an arbitration award, and a valid arbitration agreement exists, the court will order the matter back to arbitration.

Q. What do the insurance carriers think of arbitration?

A. We are aware of no official statements by insurance carriers, either for or against, the arbitration program. This may be due to the law, which states that, "A malpractice insurer shall not refuse to offer insurance to a health care provider or hospital on grounds that the health care provider or hospital has entered or intends to enter into valid written agreements with patients or prospective patients for the arbitration of cases or controversies arising out of the professional or business relationships between a patient and the health care provider or hospital."

In addition, the law obligates insurance carriers in Michigan to include provisions in policies issued which require compliance with the laws by hospitals.

Q. Why should I consider signing an arbitration agreement?

A. To help ameliorate the problems of rapidly rising premiums for professional liability insurance, diminishing availability of coverage and increasingly crowded court schedules, arbitration has been made available to doctors and hospitals in Michigan as an alternative method of resolving medical malpractice disputes. As in other situations presenting alternative solutions, a physician's best interest is served by weighing the alternatives to decide whether to participate in arbitration agreements.

In weighing the alternatives, it is important not to lose sight of the basic question: if you were the defendant in a medical malpractice suit, would you prefer to have the dispute resolved in court or in arbitration? The decision whether or not to participate in arbitration agreements should be governed by this question and not by peripheral issues.

Q. Who represents the physician, patient or hospital in an arbitration process?

A. The physician arbitrator does not represent the doctor. No arbitrator is to act as an agent or representative of any party to the arbitration. It is not intended that the panel be composed in such a way that every, or for that matter, any party has a "representative" on it. All arbitrators serve as neutral third persons with the responsibility to make decisions based on evidence presented by the parties.

The panel is composed of one lawyer, one physician or hospital administrator, and one public member to assure expertise necessary to complete understanding of the dispute. Each arbitrator is mutually selected by the parties to the case. The panel members share expertise among themselves, but do not create or add to the evidence upon which they are to make a decision.

(Continued on page 210)

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Wednesday, May 10, 1978

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Fairlane Town Center
Dearborn, Michigan

REGISTRATION:
8:30 a.m. — 9:30 a.m.

PANEL DISCUSSION:
"MOTOR VEHICLE INJURIES AND RESTRAINT SYSTEMS"
9:30 a.m. — 11:30 a.m.

LUNCH:
11:45 a.m. — 1:15 p.m.
(includes student and distinguished alumni awards, annual business meeting)

PROFESSIONAL SESSIONS:
"DAY-TO-DAY MANAGEMENT OF DIABETES"
1:30 p.m. — 4:00 p.m.

RECEPTION:
6:00 p.m.

DINNER AND AWARDS:
7:00 p.m.

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For further information call WSU School of Medicine (313) 577-1495.

Q. I have heard there are not enough arbitrators and because of this the program is in danger. Is this true?

A. No. To date, the pool of arbitrators has been more than adequate. Large numbers of applications have been received in all categories. However, more physician arbitrators are being sought to assure parties to arbitrations the opportunity to select physician arbitrators from the same specialty as any respondent physicians.

It is not possible to predict the number of cases which will be filed or the medical specialties involved, but specialties which do not appear to be adequately represented are: pathology, therapeutic radiology, neurology, pediatrics, thoracic surgery, plastic surgery, allergy, anesthesiology, colon and rectal surgery, urology and general practice.

Q. How may I become an arbitrator?

A. Applications to become an arbitrator, along with the criteria, may be obtained from:

American Arbitration Association
Medical Tibunal
1234 City National Bank Bldg.
Detroit 48226
Telephone: 1-800-482-0660

Applications in all areas are welcome as the process of building the pool of arbitrators is a continuing one.

Q. What is the American Arbitration Association? What is its source of funding?

A. The American Arbitration Association, founded in 1926, is a private (non-governmental), nonprofit organization dedicated to the resolution of disputes of all kinds through the use of arbitration, mediation, democratic election and other voluntary methods.

The Association acts neither as arbitrator nor as a representative of any party to a dispute. Through its 26 regional offices, the AAA provides lists of arbitrators and impartial administration of arbitration proceedings. In addition to case administration, the Association is continually engaged in educational and research activities on the use of informal mechanisms for resolving disputes.

The Association is funded primarily by case fees for administrative services and contributions from some 4,000 members who support and benefit from its work.

Q. What characteristics of arbitration are of interest?

A. Arbitration is a non-governmental forum which offers due process and fair decisions. The arbitration papers, evidence and hearings are private. The rules and procedures protect the rights of all parties while the process yields rational decisions based on evidence and facts presented to a neutral panel of expert arbitrators.

The arbitrators, mutually selected by the parties to the dispute, bring with them knowledge and experience in the matters in dispute. They have the ability to understand the complex, technical issues involved.

Arbitration offers speed in resolving the conflict, not because something is sacrificed in favor of expeditiousness, but because the process takes place independent of any, or all other similar, cases. The time saved in reaching the hearing as well as in the preparation and presentation of the cases is the primary factor in reducing costs of resolving the dispute.

One of the important factors of the arbitration system is that notification and identification of the problem are made early in the process. The process emphasizes early resolution.

Q. What happens if the patient signs the agreement, then brings a claim against a participating hospital and a doctor who has not signed an agreement with the hospital?

A. The claim of the patient against the hospital would be brought through arbitration. If the patient pursues the claim against the doctor, it would be through the courts unless both agree to join the arbitration between the hospital and the patient.

The doctor's non-participation in the hospital's arbitration agreements does not preclude the patient from bringing a claim against him.

Q. If a doctor has signed the arbitration agreement with the hospital, why would he want to offer the agreements in his office?

A. The hospital agreement binds patient, hospital, and participating physician to arbitrate only *hospital-related* claims. If such a claim is made, any of the parties to the agreement may invoke arbitration.

The office agreement binds patient and doctor to arbitrate only *office-related* claims. The office agreements complement the hospital-based agreements and assure that all treatments rendered by a participating physician, regardless of where they take place, will be covered by an arbitration agreement.

Q. What good is this program if the agreements expire after one year?

A. The Physician-Patient Out-Patient (doctor's office) agreements and the Hospital Out-Patient agreements expire after one year and may be renewed for the following year. However, any disputes arising out of treatment rendered during the time the agreement is in effect are subject to arbitration for all time, until barred by the statute of limitations.

Thus, agreements may expire after one year, but they do not become void.

Mr. Arford is director, Michigan Medical Arbitration and Health Services, American Arbitration Association.

Time is the test of all things.

BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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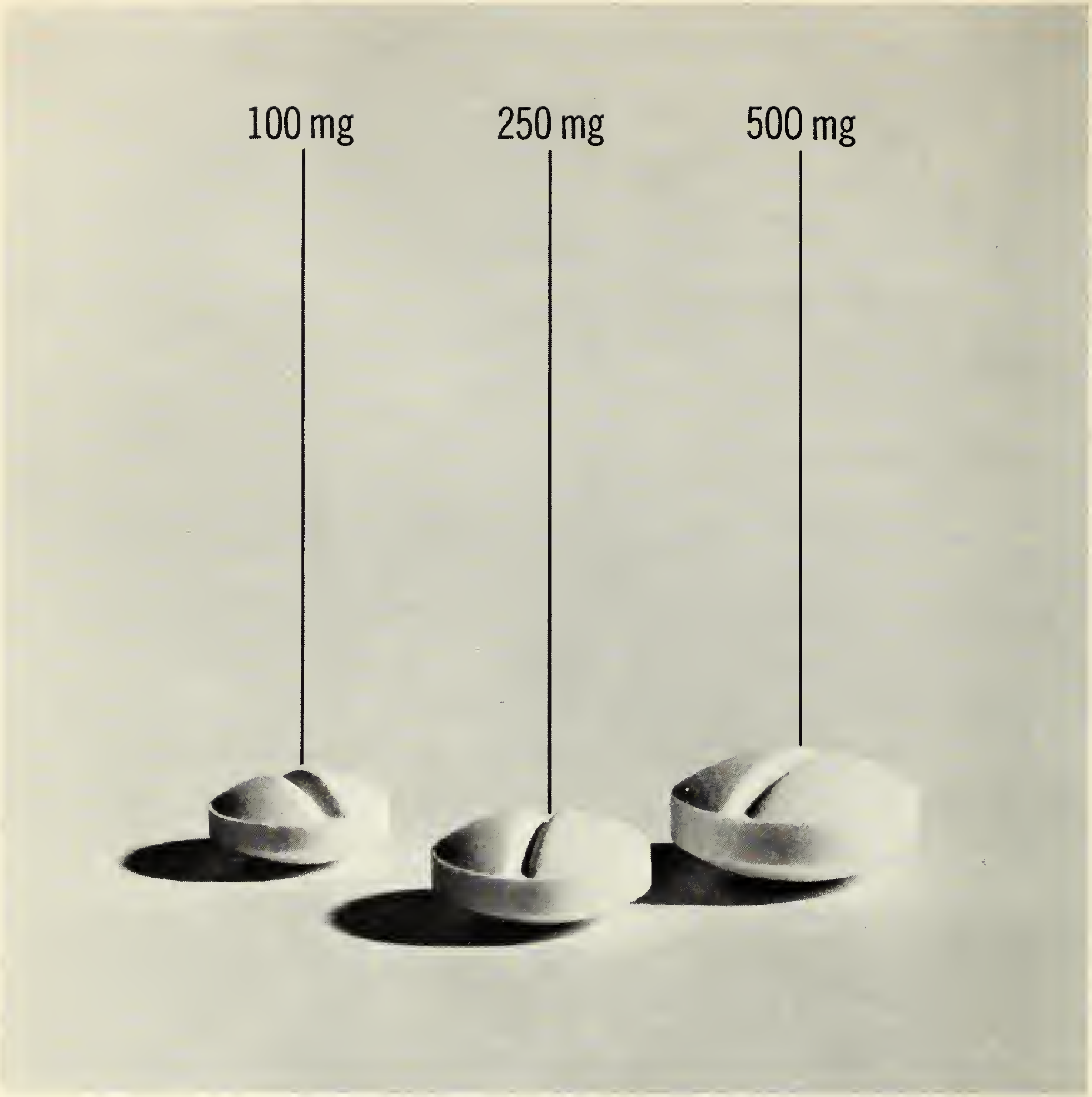
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Doctor Kennedy

Doctor Mangelsen

Doctor Tupper

Doctor Wolter

News

By Katie Brewbaker, MSMS staff

William E. Nesbitt, MD, Alpena, is the recipient of an award from Abbott Laboratories in honor of his 50 years of service to the medical profession.

Chairman of the new Department of Community Health Science at MSU's College of Human Medicine and College of Osteopathic Medicine is **Sidney Katz, MD.** Doctor Katz heads a multidisciplinary education and research staff that focuses on the ecology of health and illness, and on organization, delivery, and evaluation of health services.

Mary Anne Mangelsen, MD, a Chelsea internist, has been appointed to the Board of Trustees of Mercy College of Detroit. Doctor Mangelsen was honored as an "Outstanding Alumna" by the Michigan Colleges Foundations and a "leader in American science."

Associate Dean to the WSU School of Medicine, **Marilyn Heins, MD,** has been appointed to the Michigan State Planning Committee. The State Committee, sponsored by the American Council on Education's Office of Women in Higher Education, is part of a national program for the advancement of women in higher education administration.

Robert L. Tupper, MD, director of medical education at Blodgett Memorial Medical Center, Grand Rapids, is a new member of the executive committee of the Association for Hospital Medical Education. AHME is concerned with medical education in teaching hospitals at the undergraduate, graduate, and continuing medical education levels, and deals with problems, methods, and standards of medical education as well as requirements for accreditation for teaching hospitals. Doctor Tupper has served on the MSMS Committee on CME Accreditation since its inception.

Conrad R. Lam, MD, Detroit, is the recipient of the Distinguished Alumni Award given annually by Hardin-Simmons University in Abilene, and the Hardin-Simons Alumni Association.

Kenneth J. Ray, MD, Trenton, has been appointed a member of the American Medical Association's newly established Ad Hoc Committee on Health Planning.

A troupe of physicians and paramedics donated their time during the run of the Shrine Circus in Detroit recently to staff an "emergency room" for injured performers and ill spectators. When summoned, they packed up their medical supplies and rushed to administer medical care wherever needed. Serving as chairman was **Donald J. Kennedy, MD,** with Doctors **Edgar G. Cochrane** and **Thomas A. Tenaglia,** co-chairmen.

Ingham County Medical Society Director John Kantner recently received a letter from the Toledo Fire Chief seeking information on a "Doctor Clark" from Lansing who stopped at the scene of an accident and gave great assistance to a severely injured motorcyclist. The mystery has been solved. The "good samaritan" is **Michael Clark, MD,** of Sparrow Hospital. The full text of Chief Williams' letter was printed in the ICMS bulletin, "Medicine."

J. Reimer Wolter, MD, Ann Arbor, has been recognized for his work in the treatment of eye diseases by the Knights Templar Eye Foundation. Doctor Wolter is a long-time volunteer consultant and advisor to the Foundation.

Doctor Wilson speaks out as new Medical Practice Board head

By Jane Haradine
Special to **Michigan Medicine**

John R. Wilson, MD, new president, Michigan Medical Practice Board, has set two major goals for the board this year.

One is to promulgate the rules for physicians' assistants, and the other is to simplify the rules on continuing medical education requirements. "I want to simplify them to make it easier for the physicians to keep track of what they're doing," he says.

"We've been working on the PAs' rules off and on for about four years," he says. "There are about 200 PAs working in the state."

The delay in the rules, he explains, has been due to a disagreement between the board and the PAs on how much they should be allowed to do.

"Our rules, which would regulate the doctors who employ PAs, are strict. The PAs would be allowed to do only very minor surgery, requiring local anesthesia, nothing with general anesthesia. We feel they should be closely supervised on diagnosis and treatment and not be allowed to do this strictly on their own," he says.

He sees PAs doing histories and physicals and renewing prescriptions, but not for controlled substances. "Every drug is potentially dangerous, and we all have problems with that," he says.

"Restrictions could be eased after we gain some experience with PAs," he says. "But the physician is ultimately responsible."

Keep things smooth

Doctor Wilson's responsibilities on the board take 20-plus hours a week. Besides trying to keep up a busy practice, he is a member of the board at Butterworth Hospital. He also is one of the volunteer physicians in Grand Rapids who have spearheaded improvements in emergency medical care through the addition of E-Units, training of emergency medical technicians and by providing on-scene medical treatment at accidents.

His personal goal for the year as president: "Just to keep things running smoothly. Keep the board as much away from politics as possible. This is a responsible job that should not be influenced by politicians."

As he finished a hamburger for lunch at the restaurant claiming to make the best in town, Doctor Wilson was reminded of the "one big misconception" other doctors have of board members. "Since the offices are in Lansing, they think the doctors are bureaucrats," he says. "But we're all just like the rest of them. We've got a job to do."

A Grand Rapids pediatrician, Doctor Wilson is starting his seventh year on the licensing board. He was elected president in October, replacing Frederick W. Van Duyne, MD, of Flint.

"A few years ago, we'd only have one or two investigations on complaints," he says. "Now the attorney general's office is investigating over 100."

Some of the investigations and disciplinary actions, he says, "are terribly complex. It takes a long time before we can do anything." However, if there is an immediate threat to the public, "a license can be summarily suspended. Sometimes these are reversed by the courts. A few years ago, a judge ruled that the board had acted capriciously and without due cause and returned the doctor's license. He's still practicing."

Most against older MDs

The most common complaints, he says, are against "older physicians who just haven't kept up. Some voluntarily surrender their licenses and retire rather than have formal charges brought."

Doctor Wilson

Others are "sick doctors, who really are incompetent to practice."

Drug charges also are increasing. Most are for what Doctor Wilson terms "carelessness" by physicians, "who write prescriptions without proper indications."

Doctor Wilson does his share of reviewing complaints, and working with the attorney general's office to decide whether a charge should be filed. In many cases, doctors agree to complete more study in a specific area, such as pharmacology.

The board has 10 physicians and three lay members, all appointed by the Governor. Doctor Wilson praises the work of the lay members, saying they "are excellent." But when it comes to determining minimum standards of care, case by case, "you have to have physicians doing that," he says.

Need more support

To get the money the board needs for getting its job done, Doctor Wilson plans to "keep asking. We just need more support, not only financial, but people. We don't have enough to do the administrative work. We need two more full-time employees and more investigators. Ideally, we should be able to hire and fire our own."

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1308-35-5065	1366-35-5065	5.5F	65cm	30	900
1308-35-5085	1366-35-5085	5.5F	80cm	28	900
1308-35-66	1366-35-66	6.0F	65cm	35	900
1308-35-86	1366-35-86	6.0F	80cm	32	900
1308-35-5066	1366-35-5066	6.5F	65cm	44	900
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Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Nasir Ahmad, MD
6318 Laurentian Ct.
Flint 48504

Sylvia E. Ahronheim, MD
1410 Greenwood
Jackson 49203

Aliakbar Aliasgharpour, MD
750 Stewart Rd.
Monroe 48161

James B. Anderson, MD
45871 Forest Lake Dr. #13
Mt. Clemens 48045

Martin Atdjian, MD
3102 Lindenwood
Dearborn 48120

Antony K. Attie, MD
464 Colonial Ct.
Grosse Pte. Farms 48236

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17000 W. Eight Mile Rd.
Southfield 48076

James B. Butterfield, MD
Henry Ford Hospital
Detroit 48202

David W. Burke, MD
252 E. Lovell #140
Kalamazoo 49007

Frank C. Campbell, MD
833 Lake Drive, S.E.
Grand Rapids 49506

Ashoke K. Das, MD
12407 Schauer Dr.
Warren 48093

Sharon L. Dowd, MD
1810 Overhill Dr.
Flint 48503

Gregory C. Gifford, MD
401 W. Greenlawn #401
Lansing 48910

Alan S. Jones, MD
21 Michigan St., N.E.
Grand Rapids 49503

Kwang Sung Kim, MD
Otsego Memorial Hosp.
Gaylord 49735

Steven N. Klein, MD
3535 W. 13 Mile Rd. #704
Royal Oak 48072

Byung S. Lee, MD
35720 Green St.
New Baltimore 48047

David C. S. Lung, MD
6092 Amanda Dr.
Saginaw 48603

Manfred Marcus, MD
200 N. Ingalls
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Detroit 48201

Luis F. Ospina, MD
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Royal Oak 48072

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Saginaw 48603

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2 Hospital Drive
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Ludington 49431

William H. Rosewater, MD
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Ezzatullah Safapour, MD
326 Grandview
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William W. Schwab, MD
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1631 Gull Rd.
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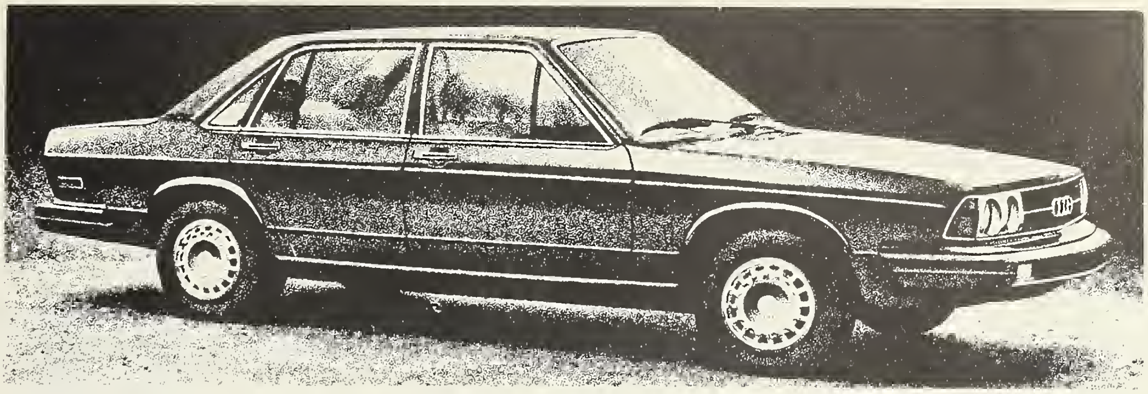
William H. Weintraub, MD
F7516 Mott Children's Hosp.
Ann Arbor 48109

John R. Wesley, MD
F7516 Mott Children's Hosp.
Ann Arbor 48109

(Continued on page 218)



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AN INTERVIEW WITH FRANZ HAUK, ENGINE DESIGNER

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Was the big problem keeping the engine in balance? Hauk: No, why? Because of the odd number? Nowhere is it written that an engine must have an even number of cylinders in order to be balanced. The plain fact is that engineers just automatically think in terms of 4, or 6, or 8, or 12. Our engine is balanced, I assure you. And it wasn't so difficult, really.

Were there any advantages to dropping a cylinder? Hauk: I didn't drop a cylinder. I wanted 5-cylinders from the start. But yes, there were several other advantages. For one thing, the shorter engine allowed for a lower look up front. A lower nose also has the advantage of cutting wind resistance and putting less strain on the engine. One less cylinder also means less weight and greater efficiency.

It's still awfully new, this engine. How do you know the bugs are out of it? Hauk: We tested 100 cars in the U.S. and Canada for so many months, we learned to order eggs "over easy." To my knowledge, no imported car manufacturer has ever done so much testing on such a large scale before. It was the only way we could truly know how the engine and the entire car perform under all your driving and weather conditions.

Why would American drivers spend $8,500* for the Audi 5000? Hauk: Well, not all American drivers would. But we feel sure that there are enough Americans who have come to know craftsmanship, fine machinery and clean design when they see it. They will also recognize that the Audi 5000 is the largest German car for the money. Yet, for all its size, it is surprisingly lively. Also, there's the room and comfort and quiet that Americans traditionally appreciate.

*Suggested 1978 retail price $8450, P.O.E., transp., local taxes and dealer delivery charges additional

See your nearby Audi dealer.

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(That message was timely when it appeared in the MSMS Journal in 1925 – 50 years ago – and it is equally timely now – the Editor.)

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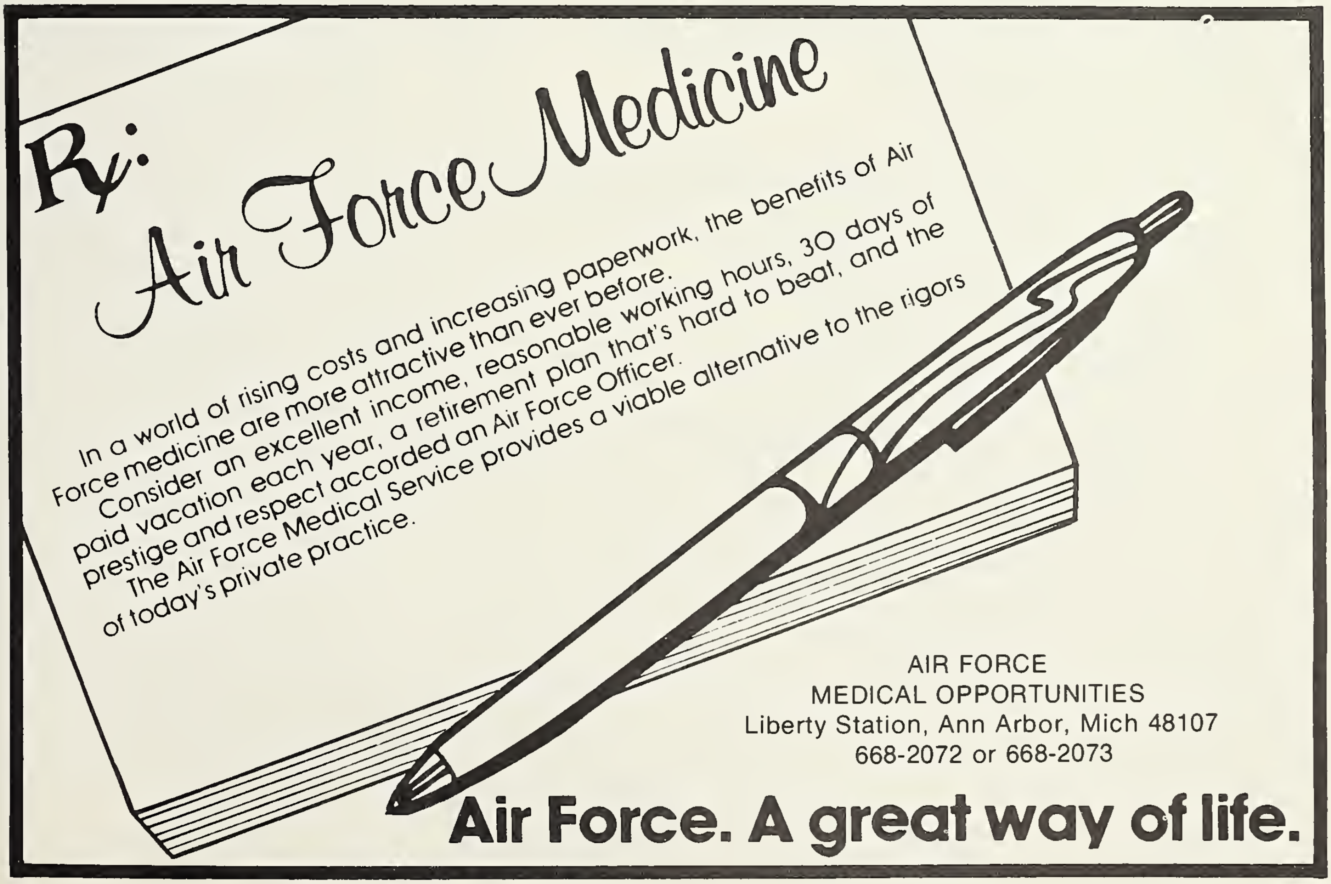

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(A handy tear-out brochure on the organization and activities of the Michigan State Medical Society appears on pages 241-244 of this issue.)

Librax®
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE
Roche Products Inc.
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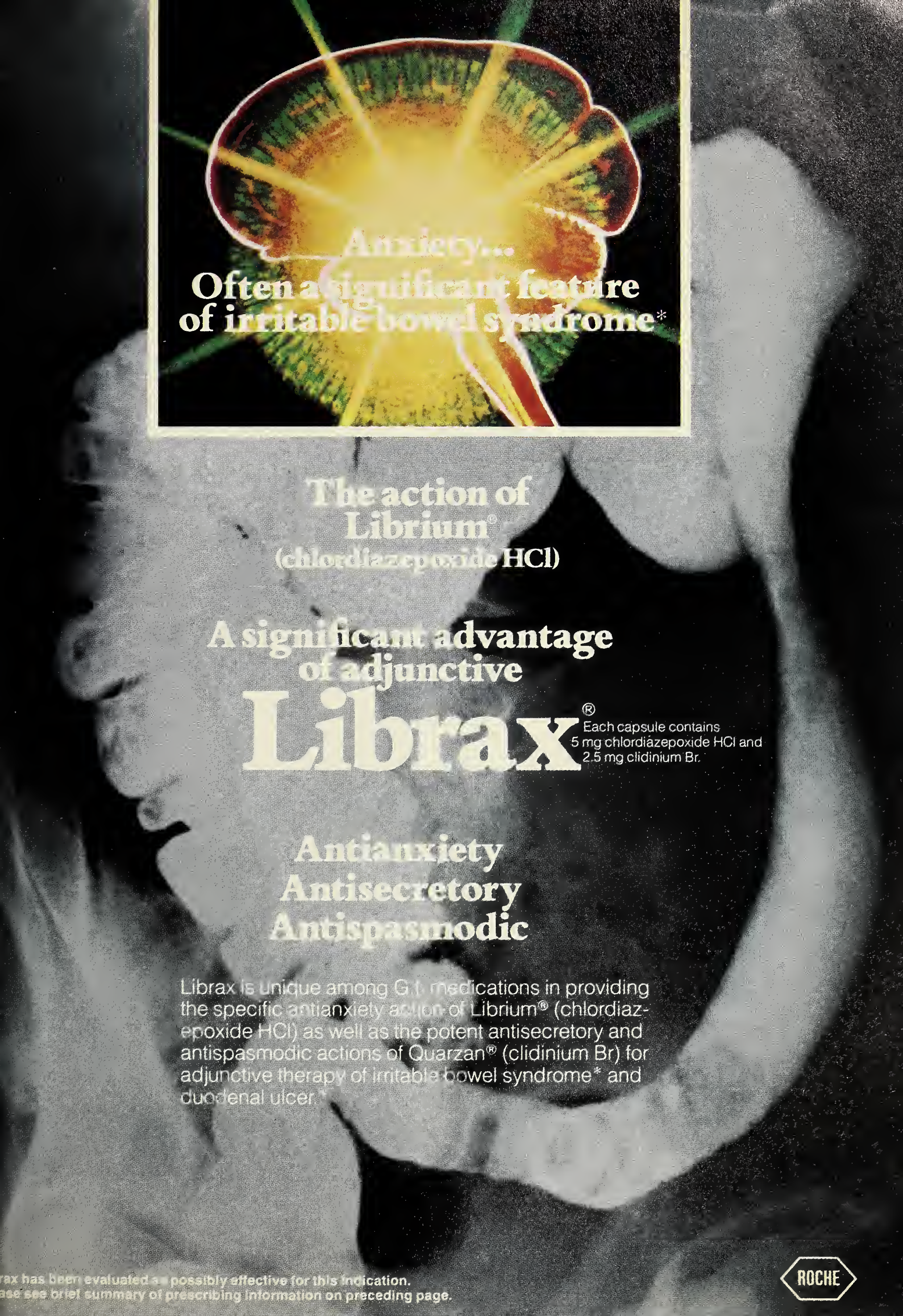

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Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

rax has been evaluated as possibly effective for this indication.
ase see brief summary of prescribing information on preceding page.

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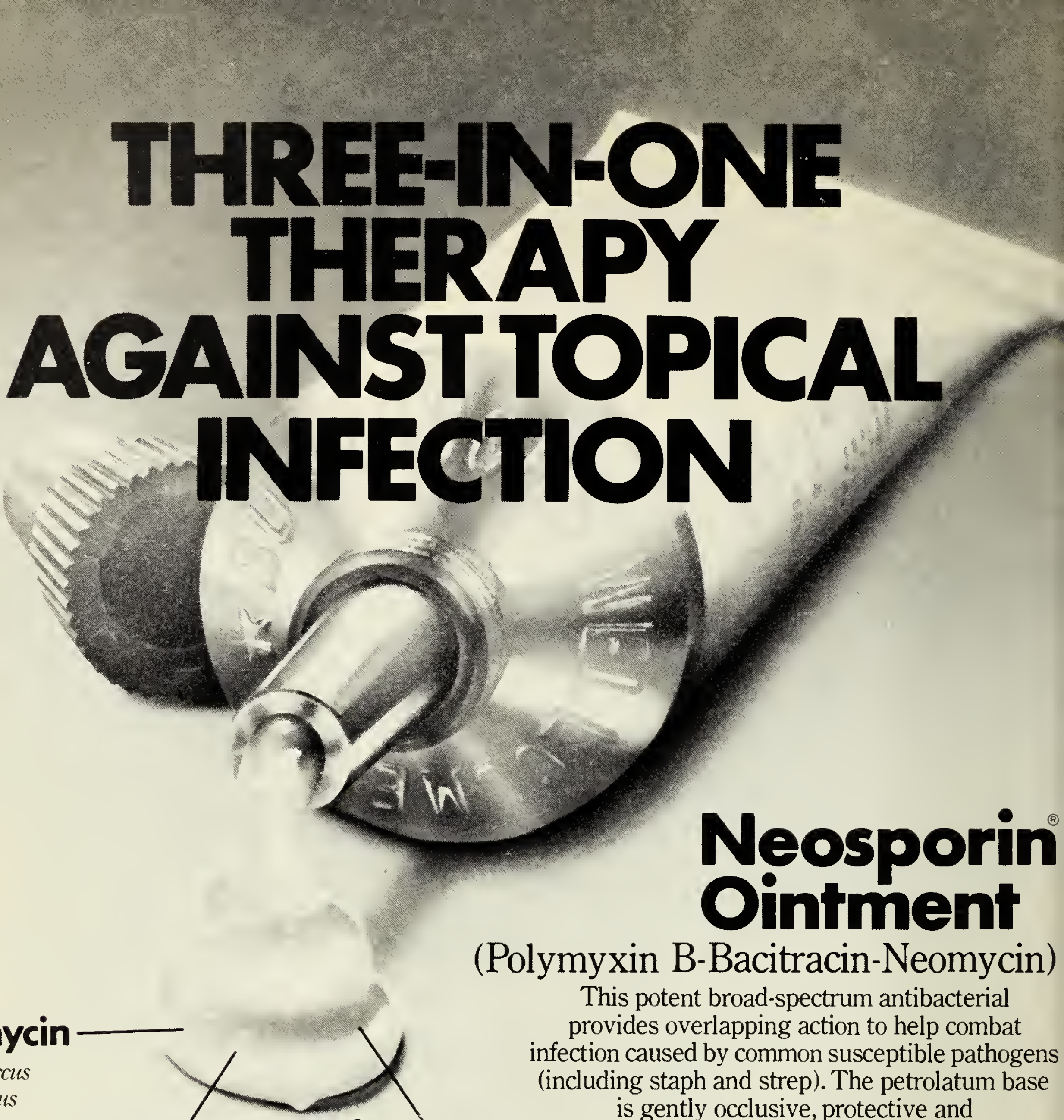

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This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin	**Bacitracin**	**Polymyxin B**
Staphylococcus	*Staphylococcus*	*Pseudomonas*
Haemophilus	*Corynebacterium*	*Haemophilus*
Klebsiella	*Streptococcus*	*Klebsiella*
Aerobacter	*Pneumococcus*	*Aerobacter*
Escherichia		*Escherichia*
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Streptococcus		
Pneumococcus		

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

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Neosporin® Ointment

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

TRIAMTERENE CONSERVES POTASSIUM
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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

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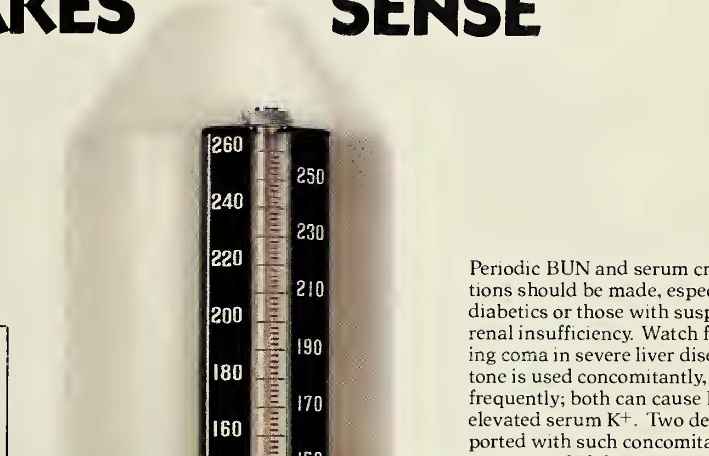

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.*
SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

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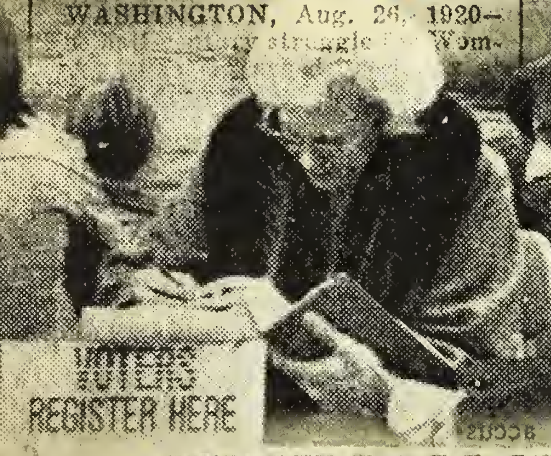
Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—[illegible] struggle [illegible] Wom-



NEW YORK THURSDAY, AUGUST 15, 19

Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws—He C the Measure 'Cornerstone' of His Economic Progra

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

WASHINGTON, Aug. 14, The Social Security Bill, pr a broad program of unempl insurance and old age pe and counted upon to benef 20,000,000 persons, became day when it was signed by dent Roosevelt in the pres those chiefly responsible f ting it through Congress.

Mr. Roosevelt cal[illegible] "the cornerstone [illegible] st which is being [illegible] me[illegible]s complete

co

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

UL SIGN the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

Views

PA 339 no satisfactory solution to public drunkenness problem

By Richard Bates, MD
Lansing

When, in the late 1950's, the AMA's House of Delegates pronounced alcoholism a disease, there was lighted a slow-burning fuse which touched off Michigan's Public Act 339.

However, since that act took more than three years of revision before it finally became law on January 15th of this year, it can scarcely be called an explosive step forward in the care of alcoholics. Especially as those revisions have changed the Act from a measure that might have brought thousands into treatment into an impotent shadow of its former self.

So worried were various pressure groups — civil libertarians, bar-owners, lawyers and law enforcers — about the possibility that publicly-drunken people might be forced into treatment against their will that the law ended up abolishing arrests for simple drunkenness without providing any other means for handling the problem.

Only the drunkest

At present, law enforcers are allowed to take only the drunkest individuals into protective custody in order to deliver them to a hospital. (Until May 15th, that means to any hospital with a licensed emergency room. After that, only one hospital per county will be permitted the doubtful privilege of receiving such patients.)

Rather than to use the scientific precision of a blood alcohol level to define how drunk one must be before he needs protection, lawmakers chose the word "incapacitated" and then tried to describe the undefinable as "a person (who) as a result of the use of alcohol, is unconscious or has his or her mental or physical functioning so impaired that he or she poses an immediate and substantial danger to his or her own health and safety or is endangering the health and safety of the public."

Well, unconscious drunks have always been brought to the hospital anyway — or they should have been — so we are left with the impossible task of determining when it is safe to leave drunken people to their own devices. The lawmakers, as in the case of laws for commitment of the mentally ill, have perhaps given us credit for more perspicacity than we possess by assuming we can always — or ever — predict when a person's behavior will be "safe" (whatever *that* is!).

Doctor Bates

A vote for .20 percent

There is one avenue out of this dilemma. The law states the law enforcer may bring people to us when they *appear* to be incapacitated but only a physician or his designated representative may make the final determination. Accordingly, if we medical people all agree among ourselves upon some rigid definition of "incapacitated," and if we all consistently stick to that standard in court, we can rescue the law from buncombe. I would propose we take a blood alcohol of .20 percent as the level of *certain* incapacitation and regard individuals with levels between .10 and .20 percent as *possibly* incapacitated, depending upon their behavior. (The Legislature has already determined 1.0 percent is the level for incapacity to drive a motor vehicle.)

Hospital emergency rooms are urged to acquire relatively inexpensive portable devices for analyzing the breath for alcohol and then to use them on everyone brought in under the Act. Such breathalyzers will permit cheap, instant determinations accurate enough to screen severe alcohol intoxication from all other types and degrees of incapacitation. Since these determinations will be ordered by physicians as a part of their confidential clinical examination, not for the purposes of prosecution, all of the objections made in the

Alcoholism consultants/trainers wanted

Programs are continuing this spring to train physicians and nurses to serve as consultants/trainers for facilities designated to emergency and approved services under the new PA 339.

The consultation and training is available primarily to emergency and service programs already designated by the Michigan Office of Substance Abuse Services. OSAS will provide two consultant/trainer days of assistance per request, although local facilities may provide training and consultation at their own expense.

The trained physicians and nurses are equipped to deal with the legal issues regarding PA 339, the medical issues associated with severe alcohol misuse, accompanying behavioral problems and problems created by emergency medical staff attitudes toward alcoholism.

Further information is available from Howard A. Simpson Jr., Michigan Department of Public Health, 3500 N. Logan, PO Box 30035, Lansing, 48909.

past to obtaining a miscreant's blood alcohol level without his consent do not pertain. There is also a "catch 22": any person cogent enough to refuse to be tested is obviously not incapacitated and can be put back on the street at once. The law requires only that he pose an *immediate* danger. If he freezes to death an hour later, well . . .

Problems need ironing

As with any new legislation, there are other problems to be ironed out, most of them beyond the purview of the practicing physician. For example, how are the hospitals to lock up, muzzle or tie down the uncooperative? Who will return the individual to his original environs, perhaps on the opposite side of the county, once he is no longer incapacitated? PA 339 requires an approved hospital to take in incapacitated persons who come voluntarily and specifically enjoins hospitals from ever refusing treatment on the basis of previous relapses or failure to cooperate. So, any diligent dipsomaniac can force himself upon a hospital's free bed and board three nights out of every week at the price of downing a pint of gin an hour before he arrives. The new law makes the individual's hospitalization a matter of confidentiality at the same time it requires his family be notified immediately he is there. Only persons incapacitated by *alcohol* come under this legislation: those who are equally incapacitated by all other intoxicants will presumably still go to jail as before.

Originally, it was expected Michigan might join some 24 other states in passing a compassionate law that would bring alcoholics from all walks of life into medical treatment, thus avoiding the endless Sisyphean toil of arresting, jailing, trying, lecturing, and then freeing inebriates to do it all over again. What we've got is a Hydra of compromise that applies only to the drunkest drunks, whether or not they are alcoholics, and requires us to let them loose as soon as they are able to stand up — much sooner than they ever got out of jail and long before they can be evaluated and, if indicated, treated for alcoholism.

Three options for reasonable

Reasonable medical citizens are left with three options: We can destroy the law by interpreting "incapacitation" as being synonymous with coma; we can leave it as it is, in which case it will be of limited application; or we can salvage a part of it while waiting for the Legislature to patch up the rest of it.

To date, everyone involved, from the Health Department down to the cop-on-the-beat, is playing it safe so emergency rooms have been underwhelmed with business. No one seems to know what's happened to the thousands of former drunk-tank denizens. Maybe they'll be found only after the snow melts. It will be longer than that — maybe until snow arrives in Hell itself — before we can expect a legal approach will provide a satisfactory solution to the problem of public drunkenness.

Doctor Bates is chairman of the MSMS Committee on Alcoholism and Drug Abuse, and has been a contributing editor to **Medical Economics.**

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Meetings

(See also listing of Category I programs on page 194).

April 13 — Medical Aspects of Organized Atheltics, Hilton Inn, Lansing, contact: Herb Auer, MSMS headquarters.

April 13 — "The Physician's Family," presented by St. John Hospital, Dept. of Health Education in Cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

April 18 — Annual Legislative Day, MSMS Auxiliary, Olds Hotel, Lansing, contact: Mrs. Thomas Berglund, 618 Aquaview Drive, Kalamazoo, 49009.

April 20-23 — 29th Annual Meeting, State of Michigan Branch, American Association of Medical Assistants, Michigan Inn, Southfield, contact: Donna Fogal, AAMA branch president, 1306 Eighteenth St., Port Huron, 48060.

April 28-29 — Annual Meeting of the Upper Peninsula Medical Society, Terrace Motor Inn, Escanaba, contact: A. Leslie Rose, MD, Doctor's Park, Escanaba, MI 49829, 906/786-4628.

May 1-3 — MSMS Auxiliary Annual Convention, MSMS Auxiliary, Bay Valley Inn, Bay City, contact: Helen Schulte, MSMS headquarters.

May 5-7 — Annual MSMS House of Delegates meeting, Hyatt Regency Dearborn, contact: Dick Campau, MSMS headquarters.

May 18 — 15th Annual Legislative Forum, sponsored by the Michigan League for Human Services, Lansing Civic Center, contact: the League office at 200 Mill Street, Lansing 48933, or phone 517-487-5436.

May 24-26 — 1978 Medical Staff/Trustee/Administrator Forum, Boyne Mountain Lodge, Boyne Falls, contact: Michael Nolan, Michigan Hospital Association, 2213 E. Grand River, Lansing, 48912, 517/484-7441.

May 25 — Western Michigan PSRO Annual 1978 Meeting, Hospitality Inn, Grand Rapids, contact: Western Michigan PSRO, 616/942-6090.

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The course will run from Aug. 28 to Nov. 22 at a cost of $923 for tuition and fees. The program provides a comprehensive review of the basic sciences, clinical sciences and patient management problems.

The Medical Review Program was initiated by the Michigan State Medical Society and later funded with HEW grants. It now is self-supporting.

Further details are available from the Medical Review Program, Center for Health Sciences, Oakland University, Rochester, 48063 (Tel. 313/377-3563.)

June 6-9 — Michigan Public Health Association Annual Meeting, Dearborn Hyatt-Regency, contact: Executive Director, MPHA, 403 Seymour Avenue, Lansing, MI 48914, 517/484-3044.

June 15 — "Insurance Programs for Family Protection and Retirement Income," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

June 17-22 — AMA Annual Meeting, St. Louis.

July 10-14 — International Automotive-Medical Meeting, sponsored by the American Association for Automotive Medicine and the International Association for Accident and Traffic Medicine, at the University of Michigan, Ann Arbor, contact: AAAM Secretariat, P.O. Box 222, Morton Grove, IL 60053.

Aug. 28-Nov. 22 — Fall Medical Review Program for FLEX. ECFMG and VQE, Oakland University, Rochester, contact: Medical Review Program, Center for Health Sciences, Oakland University, Rochester, 48063, 313/377-3563.

Sept. 14 — "Legal Problems of Ending Medical Practice," presented by St. John Hospital, Dept. of Health Education in Cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Oct. 12 — "Pre- and Post-Retirement Medical Care for the Physician and His Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

***Nov. 7-9* — MSMS Annual Scientific Meeting, Detroit Plaza Hotel, contact: Herb Auer, MSMS headquarters.**

Nov. 23 — "How Do I Know When to Retire?" presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

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*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

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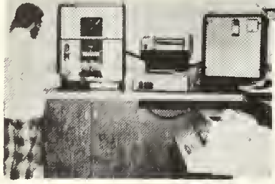

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Deaths

Stilson R. Ashe, MD
Dearborn

Stilson R. Ashe, MD, Dearborn, 91, died Feb. 11. Doctor Ashe graduated from Wayne State University School of Medicine and served on the staffs of Booth Memorial, DelRay General, and Oakwood hospitals.

Walter D. Buzzard, MD
Fort Walton Beach, Florida

Walter D. Buzzard, MD, Fort Walton Beach, Florida, died Jan. 29 at age 72. Doctor Buzzard received his medical degree from the University of Michigan Medical School. He was past chief of staff at Owosso Memorial Hospital and was a past president of Shiawassee County Medical Society.

Earle A. Irvin, MD
Virginia

Earle A. Irvin, MD, Virginia, died Jan. 8 at 70 years of age. A graduate of the University of Michigan Medical School, Doctor Irvin was a past president of the Michigan Heart Association and a member of the American College of Chest Physicians.

Elmore F. Lewis, MD
Jackson

Elmore F. Lewis, MD, Jackson's oldest practicing physician, died Jan. 23 at the age of 84. Doctor Lewis obtained his medical degree from the University of Michigan Medical School and was affiliated with W. A. Foote and Mercy hospitals, Jackson. He was a past-president of the Jackson County Medical Society and was a member of FACS as well as the American College of Surgeons. Doctor Lewis was cited by MSMS for his 50 years of service.

William A. McClure, MD
Boynton Beach, Florida

William A. McClure, MD, Boynton Beach, Florida, died Dec. 2 at the age of 91. Doctor McClure, a graduate of the University of Michigan Medical School, was a member of the International Board of General Surgeons as well as the Detroit Academy of Surgeons. He was a former head of the surgery department at Highland Park Hospital, Detroit.

Alton R. Marsh, MD
Good Hart

Alton R. Marsh, MD, Good Hart, died March 8, 1977, at the age of 82. A general practitioner, Doctor Marsh graduated from Wayne State University School of Medicine and was a member of the former Academy of General Practice, Wayne County.

Karl L. Miller, MD
St. Clair Shores

Karl L. Miller, MD, St. Clair Shores, died Feb. 19 at the age of 67. A graduate of Wayne State University School of Medicine, Doctor Miller was a former chief of obstetrics and gynecology at Grace Hospital, Detroit. He also was a clinical instructor of obstetrics and gynecology at the Wayne State University School of Medicine. He was a member of the Michigan Society of Obstetrics and Gynecology and was a captain in the U.S. Army Medical Corps during World War II.

Robert J. Schneck, MD
Grosse Pointe Farms

Robert J. Schneck, MD, Grosse Pointe Farms, died Feb. 2 at the age of 76. Doctor Schneck was a graduate of Harvard Medical School, and was former vice-chief of staff at Detroit's Harper Hospital. He was a former professor in clinical medicine at Wayne State University. His numerous memberships included the National Heart and Diabetes Association and the American College of Physicians.

Albert E. Vossler, MD
Ontario, Canada

Albert E. Vossler, MD, Ontario, Canada, died Jan. 19 at the age of 80. Doctor Vossler graduated from Wayne State University School of Medicine and was affiliated with Harper, St. Joseph and St. John hospitals, Detroit. He was a fellow of the American Academy of Opthalmology and Otolaryngology, and the Pan-American Congress of Ophthalmology. He served as associate professor at the Kresge Eye Institute.

James L. Wilson, MD
Ann Arbor

A pioneer in the early treatment of polio patients at the University of Michigan Hospital, James L. Wilson, MD, Ann Arbor, professor-emeritus of pediatrics and communicable diseases and former chairman of that department, died Jan. 28 at the age of 80. The James L. Wilson Research Laboratory in Pediatrics at the U-M Mott Children's Hospital is named after Doctor Wilson. A past president of the American Pediatrics Society and a leader in pediatrics research, Doctor Wilson was involved with Jonas Salk, MD, another former U-M faculty member and developer of the Salk Polio vaccine, and the U-M's late Thomas Francis, Jr., MD, in nationwide testing of the vaccine. Doctor Wilson was a graduate of Harvard Medical School. He was recipient of the American Board of Pediatrics' Abraham Jacobi Award for outstanding contributions in the field. In 1976 he was honored by MSMS for 50 years of contributions to pediatrics.

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Hospital staff privileges reviewed in article

MSMS legal counsel recommends that MSMS members read the article, "Judicial Review of Medical Staff privileges in Private Hospitals," appearing in the October 1977 issue of *The Journal of Legal Medicine.*

Author Alan K. Cotler, MBA, JD, Alexandria VA, says, "In analyzing legal trends, one finds the law has evolved from the arguments of public policy and public interest to the legal principle of state action and now seemingly has returned to public interest. Only now a delicate procedural balance is being struck between physician and hospital interests.

"To define what is in the public interest one must look at state involvement. What is really happening today is that the public policy argument and state action concepts are nearly one and the same. But by avoiding the term "state action," the forum for judicial review is on the state level and not in the federal courts.

"In effect," Cotler continues, "the courts are asking hospitals to fairly police their own borders for their own sake. The physician and hospital must work together to reach fair and just decision. A court will intervene, however, to ensure that both due process for the physician and the ability to maintain quality medical care by the hospital are met. In weighing the interests of physician and hospital, regardless of the legal concept used, the deciding factor that inevitably will tip the scale is what is best for current and prospective patients."

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PSYCHIATRIST for hospital. Direct inpatient service and office practice. $50,000 guarantee and free malpractice. No fee to applicant. Contact: Medical Recruiters of America, 500 S. Racine, Suite 312, Chicago, IL 60607, phone 312/942-1146.

WANTED — INTERNIST OR FAMILY PRACTITIONER to join new prepaid group practice program located in northeast Detroit suburb. Must be Board Certified or eligible; good hours, benefits and salary. Send resume to H. Richard, 21000 Mound Road, Warren, MI 48091.

INTERNISTS FOR PRIMARY CARE UNIT, Hospital based practice in Ann Arbor, Michigan available July 1, 1978. Faculty appointment with house staff teaching through affiliation with the University of Michigan. Salary to $40,000 plus, depending on qualifications, with Federal Civil Service benefits; an equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, MI 48105.

INTERNISTS — FAMILY PRACTITIONERS, positions available September 1, 1978 at new VA Outpatient Clinic located in Toledo, Ohio. Salary to $40,000 plus, depending on qualifications, with Federal Civil Service benefits: an equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, MI 48105.

MEDICAL DIRECTOR for new VA Outpatient Clinic opening in Toledo, Ohio September 1978. Desire IBIM and demonstrated administrative ability. Salary to $50,000, depending on qualifications, with Federal Civil Service benefits; an equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, MI 48105.

FAMILY PRACTITIONERS, INTERNISTS, and/or OB-GYNs needed in growing, prosperous Dutch community to join a Board Certified family physician in existing practice, or solo available. Excellent economy with medical education, recreational lakes, and ski resorts within 20 mile radius. Will help solo practice to start out. Guarantee net income of $40,000 for first year partner. Call Grand Rapids, MI, 616/531-9803 between 9 and 11 p.m.

GENERAL PRACTITIONER — to provide medical care in a small state hospital for the mentally ill and mentally retarded located in Michigan's beautiful Upper Peninsula. Current salary $37,855 plus a liberal Civil Service benefit package. Write Steven A. Meyers, M.D., Chief of Clinical Affairs, Newberry Regional Mental Health Center, Newberry, MI 49868.

STAFF PSYCHIATRIST in an innovative adult component of a community mental health program. Would function as medical staff person on interdisciplinary team. Work includes direct service as well as providing consultation and education to CMH staff, other agencies, groups and individuals in the community, and development of prevention programs. Possession of license to practice medicine in Michigan and completion of three years psychiatric residency required. Board Certification or eligibility and experience in mental hospital or clinic desirable. Salary range — $33,000-$45,000 (commensurate with experience) plus fringes. Located in exceptionally desirable northern Michigan community of approximately 45,000 on Lake Michigan. Outstanding outdoor recreational opportunities, good family environment, cultural opportunities through nationally recognized Interlochen Arts Academy. For more information write or call Adult Mental Health Services, 442 E. Front, Traverse City, MI 49684, 616/941-8330. EOE.

PHYSICIAN WANTED — St. Clair, Michigan. Join established physician in busy family and industrial practice, arrangements open, income excellent, maximum paramedical help, maximum time off. 313/329-2020.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park, there are openings for physicians board qualified as internists, family physicians or psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently over forty thousand per year, plus 23 percent fringe benefits, including life, accident, long term disability, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7789.

STAFF PHYSICIANS — (East Lansing — Ingham Cty.) Michigan State University is currently recruiting for staff physicians. One of the 10 largest universities in the nation with an enrollment of over 40,000. Located in a metropolitan area of 250,000. The Olin Memorial Health Center, located on the campus, provides facilities for students in need of medical, acute surgical or psychiatric care. It is a well-equipped general hospital with a large outpatient section. Position would be full time with 30-day paid vacation. Physicians must be licensed to practice in Michigan or immediately capable of obtaining such license. Facilities include a completely outfitted office suite; no other equipment needed. Professional work is essentially in the category of general practice with surgery confined to the limits of the individual's experience. No pediatric, geriatric or obstetrical services provided. Staff physicians rotate on night calls and weekends. Fringe benefits include Social Security, term life insurance, malpractice insurance, and staff privileges for University cultural programs and intercollegiate athletic events. Minimum starting salary $30,000 annually. Contact: John D. Siddall, D.O., Director, Olin Memorial Health Center, Michigan State University, East Lansing, MI 48824.

MEDICAL DIRECTOR: For 206-bed chronic disease facility to work in a dynamic, challenging program with a progressive medical and paramedical team. Salary $43,000. Excellent fringe benefits as an employee of Macomb County: generous retirement program; longevity compensation; paid liability and professional malpractice; Blue Cross/Blue Shield with prescription rider; life insurance; 13¼ holidays; sick leave. Qualifications: Physician licensed to practice in Michigan. Special emphasis will be placed on additional qualifications specific to a chronic disease and long-term rehabilitation program. Contact Raymond D. Pietrzak, Administrator, Martha T. Berry Memorial Medical Care Facility, 43533 Elizabeth Road, Mt. Clemens, MI 48043. Phone 313/469-5623, ext. 24.

FAMILY PRACTICE PHYSICIAN OR INTERNIST, Applicant must be interested in General Family Medicine for five Integrated Clinics in city and suburbs. Complete laboratory and nuclear medicine. Foreign graduates must have state license. Liberal salary. Call or write TRAIL CLINICS, P.C., Cindy Papuga, Clinic Secretary, 18254 Livernois, Detroit, MI 48221, 313/861-4400.

Positions wanted

PHYSICIANS ASSISTANT will graduate in October 1978 from an AMA accredited program specializing in primary care. 27-year-old male, married with two children. Have experience as senior medical corpsman for six years and 1½ years in a professional nursing school. Would like to practice in western or northern Michigan, but all opportunities considered and appreciated. For more information, call 314/445-7233 or write Daniel E. VanderMolen, 4454 Bellview, Apt. C, Columbia, MO 65201.

Miscellaneous

ASPEN MUSHROOM CONFERENCE — Identification of edible, poisonous, and hallucinogenic mushrooms. Treatment of mushroom poisoning. Microscopy. Novice and Advanced courses. AMA Category I. August 13-18, 1978. Wildwood Inn, Snowmass-at-Aspen, Colorado. Contact Beth Israel Hospital, 1601 Lowell Blvd., Denver, Colorado 80204. 313/825-2190 Ext. 359.

FOR LEASE: Medical Suite available for lease, 1800 sq. ft. Located on Schoenherr and 11½ Mile Rd., Warren, MI. Close proximity to major hospitals. Call 313-755-1410.

PRESTIGE PLUS — OFFICE BLDG. IN CHARLEVOIX. Beautiful location and view, 217 feet of frontage on Lake Michigan, 139 feet of frontage on Michigan Avenue. Modern two-level building, approximately 4,400 sq. ft. Twelve attractive offices with room for additional suites. Many extras, four fireplaces! Great use as single residence — two separate homes — home/office combination — or all offices. Zoning (P.O.) permits building to be enlarged — very versatile — Price $169,500 — for details, call Thomas Duke, Jr. — 313/474-7744 — 32716 Grand River, Farmington, MI 48024.

SIX MEDICAL OFFICE SUITES — all new medical center in prime location of Brighton. 1150 square feet to 3000 square feet office units, includes four exam rooms or more, private office and entrance, laboratory, excellent parking, ideal to accomodate one or two doctors. Spring or summer occupancy. Call Davis Professional Bldg., 313/229-2752 or 313/229-7525.

HISTORIC newly remodeled beautiful professional offices. Located above Romeo Valley Medical Center in beautiful downtown Romeo. Available immediately. Terms to be negotiated. Write P.O. Box 429, Romeo, MI 48065.

36 175.00

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the Four-week Period Ending Feb. 24, 1978

	1978 This 4-Week Period	1977 Same 4-Week Period	1978 Total To Above Date	1977 Total Same Date	Total Cases for 1977
Rubella	175	121	359	175	1,160
Cong. Rubella Syndrome	0	0	0	0	3
Measles	558	118	906	207	1,392
Whooping Cough	4	2	5	3	73
Diphtheria	0	0	0	0	0
Mumps	215	304	383	486	2,339
Scarlet Fever & Strep Sore Throat	3,283	3,140	6,260	6,039	31,047
Tetanus	0	0	0	0	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	153	245	313	518	2,686
Salmonellosis (other than S. typhi)	77	66	158	162	989
Typhoid Fever (S. typhi)	2	2	2	4	13
Shigellosis	16	34	27	77	352
Aseptic Meningitis	6	8	16	15	207
Encephalitis	12	3	13	8	59
Meningococcic Meningitis	9	3	14	6	51
H. Influenzae Meningitis	4	16	17	25	151
Tuberculosis	88	138	135	216	1,279
Syphilis	75	98	135	176	1,151
Gonorrhea	2,255	2,381	4,579	4,778 *	36,883

Information can be supplied by the local health department on local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

*Correction

WHO TO CALL AT MSMS HEADQUARTERS

AMA Delegation	Warren Tryloff, Vada Davis
AMSA-MECO	Mert Scholten
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross/Blue Shield	John Richards
Continuing Medical Education:	
Accreditation	Marce Ireland
Category I Calendar (For *Michigan Medicine*)	Kay Rinck
MSMS Sponsored Conferences	Herb Auer
Doctor-Of-The-Week Legislative Project	Gary Anderson
Dues Payments	M. C. Lee, Peg Berry
Financial Operations	John Anthony
Foreign Medical Graduates	Mert Scholten
Governmental Agencies Liaison	Sherry Wellman
Health Career Information	Kay Rinck
HMOs (Health Maintenance Organizations)	Richard Campau
Impaired Physicians	Vada Davis
Jail Health Project	Richard Campau
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health:	
Committee	Helen Schulte
Conference	Herb Auer
Medicaid	Sherry Wellman
Medical Assistants	Helen Schulte
Medical Auxiliary	Helen Schulte
Medical Education	Herb Auer
Medical Ethics	Vada Davis
Medical Practice Board	Sherry Wellman
Medigram	Judy Marr
Meeting Information (National, State)	Kay Rinck
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Doctors Political Action Committee	Gary Anderson
Michigan Medicine (MSMS Journal)	Judy Marr
Michigan Physicians Mutual Liability Company	Bill Cheeseman (call 517/351-1150)
Michigan Psychiatric Society	Helen Schulte
Michigan Society of Anesthesiologists	Helen Schulte
Michigan Society of General Surgeons	Helen Schulte
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates:	
Agenda and Schedule	Richard Campau
Meeting Arrangements	Wayne Burmeister
MSMS-Spsonsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
MSMS News Relations	Mert Scholten
Negotiations	Bill Madigan
Physicians Assistants	
Certification	Sherry Wellman
Programs	Mert Scholten
Practice Management Seminars	John Richards
Professional Liability Insurance	Bill Madigan
PSRO/Peer Review	Richard Campau
Socio-Economic Surveys	John Richards
Specialty Societies:	
Information	Katie Brewbaker
Council of Specialty Societies	Herb Auer
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society
120 West Saginaw
East Lansing, MI 48823

MSMS PHONE: 517/337-1351

Michigan State Medical Society – working for you in many ways

Why do more than 9,000 doctors belong to the Michigan State Medical Society? Because it serves as a forum for discussion and policy making. It can speak as a unified voice for physicians. And it offers a wide range of services, both to total membership and to individuals with specific concerns.

It blends the traditional concerns of medicine along with innovative new programs such as better office management, negotiations workshops for interested doctors and increasing liaison with private and government agencies.

Today, membership stands at an all-time high, with a staff of 30 to coordinate activities and offer expertise in the areas of communication, socioeconomics, legislation, and continuing education.

The 28-member Council serves as the board of directors for MSMS, conducting the business of the Society at regular meetings.

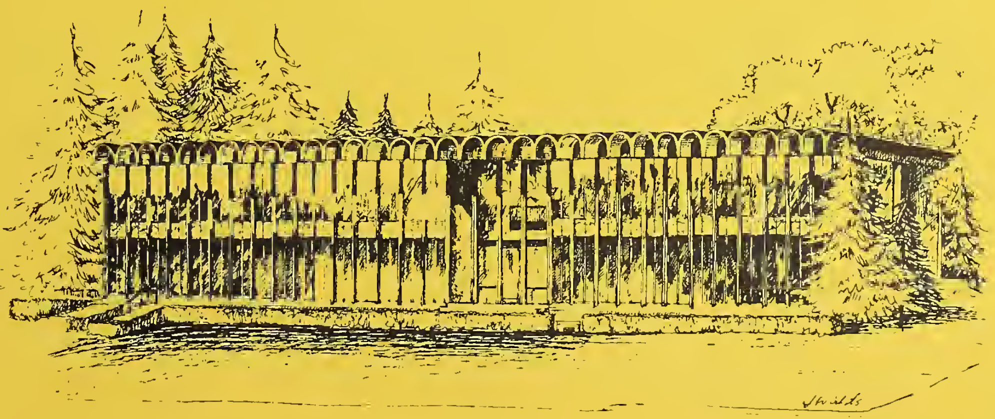
Recently both committee and staff structures were streamlined for greater flexibility. A large number of committees were telescoped into three categories. They include *Standing Committees* which deal with continuing topics such as scientific advancement and legislation; *Liaison Committees* which foster MSMS dialogue with appropriate organizations and agencies; and *Task Forces* which will be created by the Council as needed. Each major committee will include a member of the Council so that communications are assured.

Staff structure also has been changed to support new programs which have begun over the past few years.

Director Warren F. Tryloff is responsible for the operation of the staff, headquartered in a distinctive East Lansing building designed by noted architect Minoru Yamasaki. Warren joined MSMS in 1954 and has been director since 1970.

Division of Public Service, Communications, and Physician Education. Six staff people work to "get the message across," to public, the media, and members and to plan and implement all MSMS-sponsored Category I CME programs.

Through printed materials, members keep informed of society activities and policies. *Michi-*



gan Medicine, the monthly magazine, has switched to a general interest format, to the pleasure of readers who enjoy its mix of special articles, vital statistics, office management tips, and a lively letters column.

Medigram, a biweekly, carries condensed information on late-breaking medical news.

To inform the public of current medical thinking, the division services the news media. Releases are sent to dailies and weekly papers, and physician speakers are suggested upon request of radio and TV stations. Medical writers may call for background information and sources of news and feature stories. News conferences are occasionally called to give the MSMS viewpoint on current issues.

A monthly half-hour show, *Housecall,* on Detroit's Channel 56 is sponsored by MSMS and the tri-county component societies. Saginaw and Kent County also carry monthly medical programs, with the support of MSMS and local medical societies.

The annual Scientific Meeting, more than 100 years old, is recognized as outstanding. More than 50 half-day courses are given by physicians from within and outside the state.

Herbert Auer, a MSMS deputy director, is responsible for this Division. He joined MSMS in 1959.

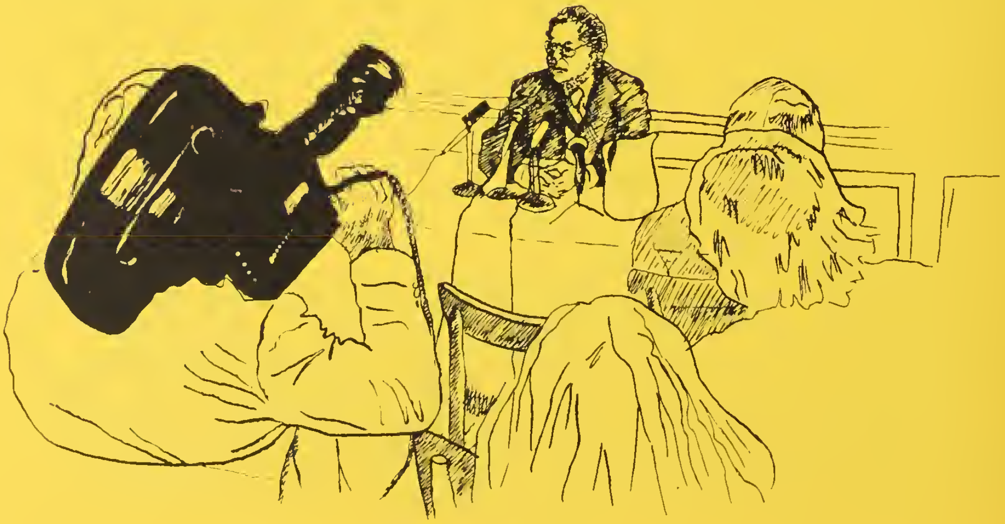
The Division of Government Relations works closely with physicians, as it monitors the hundreds of bills introduced in the legislature each year.

Recognizing the increasing information that must be exchanged between doctors and state health care agencies, MSMS employs a staff person to serve as a liaison. A typical work week may include meetings with the Michigan Hospital Association, the Medical Practice Board, the Department of Social Services, and various business and service organizations. A large part of the day's work is spent on the phone answering telephone queries from doctors on matters such as Medicaid services.

The division director notes that legislation increasingly involves the regulation of the medical profession. He pays particular attention to the more than 200 bills that each year directly affect medical and health care. Through a strong MSMS committee and a legal counsel, MSMS supports legislation that will assure the professional integrity of members.

Working in concert with the MSMS Federal Legislation committee, the Division interprets the effects of federal laws and how doctors in Michigan can respond to them.

When necessary, task forces are used to study legislative issues and give policy statements. The



Department of Government Relations provides staff and counsel for three influential programs:

Doctor-Of-The-Week-Program utilizes the talents of individual physicians in lobbying efforts. The physician arrives at the MSMS offices for a briefing on pending legislation. He spends the rest of the week at the Capitol.

Component societies' meetings with legislators "back home" provide continuing contact between legislators and the physicians in their constituencies. Several component societies, with MSMS support and advice, hold regular sessions with legislators in their home districts.

MDPAC (Michigan Doctors Political Action Committee) is a voluntary nonprofit group of physicians, spouses and other interested persons. It functions separately from MSMS as an autonomous organization. On a bipartisan basis, it supports political candidates sensitive to the needs of organized medicine. In addition, it keeps doctors informed of medical-political issues and gives them an avenue for concerted action.

Bruce Ambrose, a MSMS deputy director, is responsible for this Division. He joined MSMS in 1970.

Department of Economics, Negotiations and Finance. Since it began as the Bureau of Economics less than a decade ago, this department has assumed major importance. It is concerned with fiscal matters, both for medicine as a whole in its relationships with insurance companies, hospitals, the government and the public; and in its assistance to individual doctors working for efficient office management.

The Bureau of Finance is responsible for MSMS internal fiscal conduct, including dues collecting and work with the MSMS Finance Committee.

The *Bureau of Negotiations and Special Projects* is newly established. It has three important functions: 1) It oversees negotiations between trained physicians and other groups such as insurance companies, hospitals and government; 2) It works with professional liability issues; 3) It provides socioeconomic data to doctors.

The Bureau also is involved with monitoring the professional liability arbitration process. Michigan is one of 10 states having voluntary arbitration laws. At this writing, 20 cases are pending a hearing.

Professional liability is a continuing concern of the Bureau as it collects data from state insurance companies. In the recent past, it worked with doctors to form the Michigan Physicians Mutual Liability Company. Now it is studying long-range methods of dealing with malpractice situations.

The Bureau of Economics provides timely socioeconomic information for Michigan physicians. Its seminars on practice management, begun in 1975 for new physicians, have been expanded for general membership, and specialized for residents.

The Bureau also conducts careful statistical studies which profile medical matters in the state.

The Bureau is analyzing malpractice insurance claims, with the goal of understanding the reasons for claims and designing programs to alleviate problem areas. It is also conducting health manpower demographic studies, a profile of physician mobility in Michigan, and research into factors involving hospital length of stay.

Economic analyses of proposed federal and state health care programs also are made and submitted to appropriate MSMS committees and the Council.

John Anthony, who joined MSMS in 1971, is manager of this Department.

The Department of Health Care Delivery is involved with a number of efforts. The Department staffs the MSMS Committee on Medical Costs which was directed by the House of Delegates in 1977 to develop educational programs on medical cost effectivenes.

The Department keeps Council informed on Michigan's developing health maintenance organizations, and continues liaison with the state's nine established and emerging PSROs. It also attends BC/BS meetings in an informational capacity, to keep current with program developments.

In a continuing effort, the Department oversees research on health care in four Michigan jails, to compile information for an AMA pilot program begun two years ago. These four jails were accredited in August 1977 at the AMA National Jails Conference. The project is being conducted in cooperation with the Michigan Department of Corrections, and will provide needed information about health problems, facilities, and costs of caring for inmates.

Staffing the House of Delegates meeting is also a department responsibility, along with overseeing most aspects of the meeting and publishing a digest of the proceedings. The department also implements House of Delegates resolutions through staff assignments. Manager of this Department is Richard Campau, who has been with MSMS since 1960.

The Department of Operations and Member Services is responsible for physical management at MSMS programs, workshops, and headquarters building.

It is an integral part of MSMS' more aggressive shift toward recruiting new members. The Department now receives the names of all newly licensed physicians, and sends an appropriate letter to each person, with a copy forwarded to the component society.

It also offers members a number of professional and personal insurance plans for physicians, including office overhead, accident and health, disability income, life — both permanent and term, and disability for employees.

In addition, it serves several accounts for health-related organizations through its Office of Special Services. It provides quality executive secretary skills and computer service. The computer is available for a monthly fee to any competent society, specialty group or hospital requesting it.

Manager of this Department is Wayne Burmeister, who joined MSMS in 1974.

1866

Michigan State Medical Society
120 West Saginaw
East Lansing, Mi 48823

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

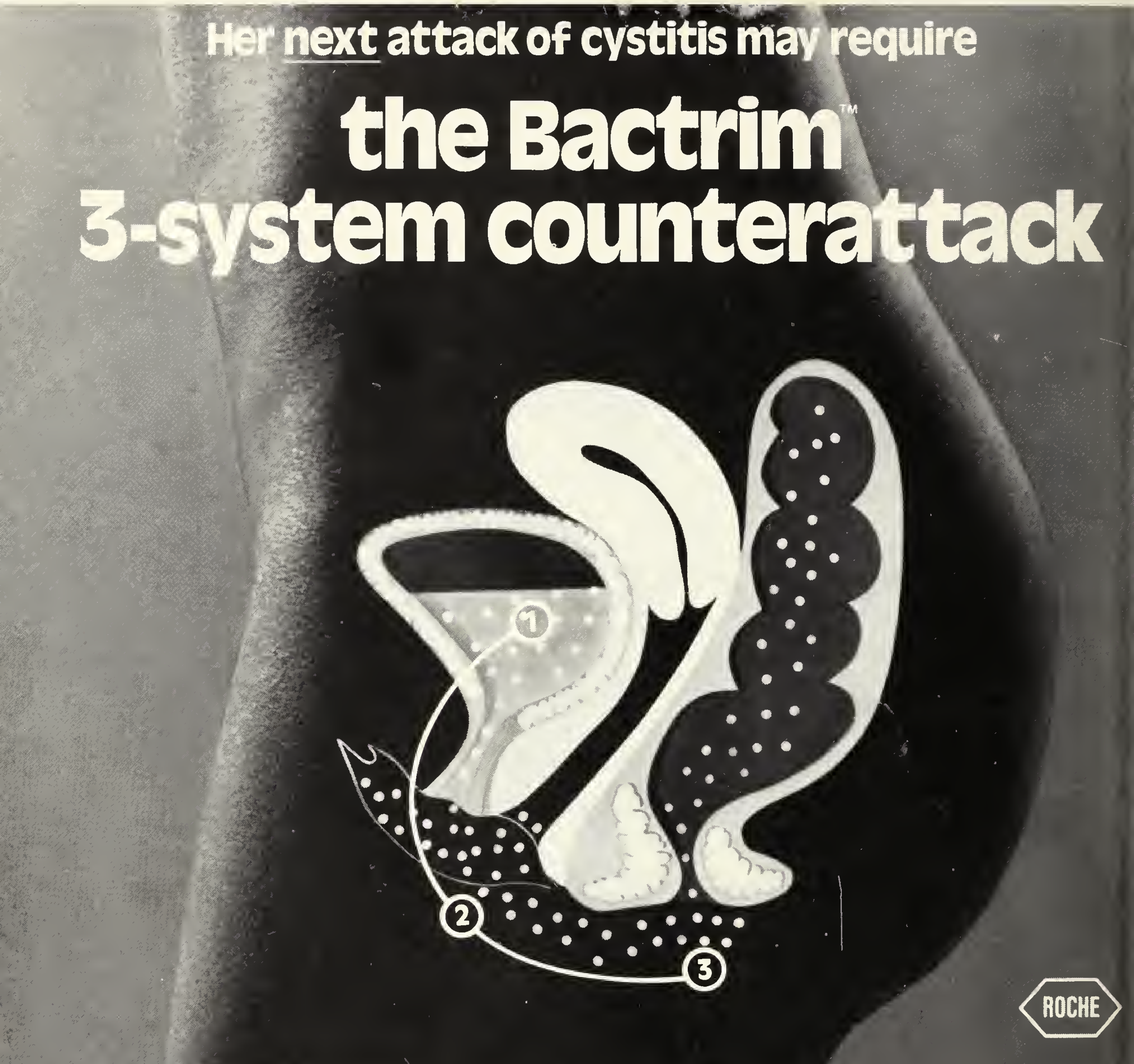
ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Return Postage Guaranteed

MICHIGAN STATE MEDICAL SOCIETY
120 W. Saginaw
East Lansing, Michigan 48823



Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introita colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 12 APRIL 13, 1978

NEW BUILDING TO COMPLEMENT, EXPAND MSMS FACILITIES

By Judith Marr
Managing Editor

MSMS leaders and others closely involved with the MSMS headquarters addition are assured the new building will blend well with the present structure and be practical for growth of MSMS activities.

In 1974 the Board of Managers and Finance Committee began a space-need study. Last year they determined new space is needed immediately, and space should be leased to acceptable tenants to achieve cost-effectiveness. The House of Delegates' Ways and Means Committee is being consulted throughout the project and notes the impact on the annual budget will be minimal due to lease income.

The total plan is being carefully integrated to complement the distinctive Yamasaki design of the present building. "The addition will be both visually sympathetic and subordinate to the existing building, which has strong symbolic value to MSMS," says Carl Luckenbach, AIA, chief architect. "Estimated cost of construction is just over $1 million. If the project had been deferred for another year, construction costs would be up by $130,000 to $150,000."

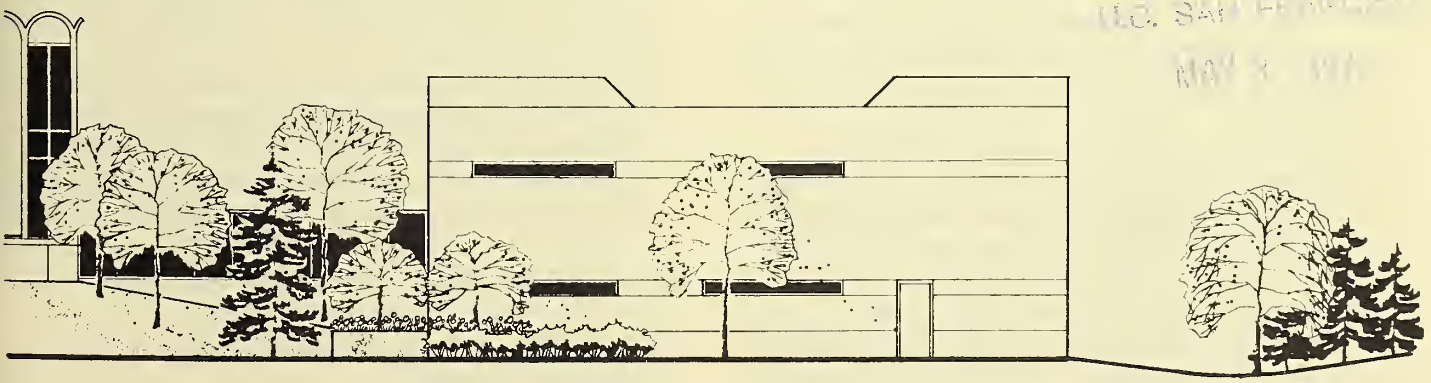
MSMS Judicial Commission action in unethical lab practices

In connection with recent media accounts about some questionable clinical laboratories, the Judicial Commission again reminds members of a memo sent early this year to component society leaders. The Jan. 26 memo asked component ethics committees to investigate and act promptly against any physician-members who engage in unethical conduct in the operation of clinical labs.

John M. Malone, MD, Commission chairman, urged each component society to be especially alert for instances in which physicians appear to be engaging in unethical conduct, to actively investigate these instances and take prompt, appropriate action. The Commission recognized these few offending physicians may not be members and not subject to society disciplinary action. However, local medical societies sometimes are aware of illegal acts by non-members, and the Commission asked any such knowledge be transmitted to the Medical Practice Board.

This action is one of many efforts by the Commission to bring an end to any unethical or illegal activities by a few physicians. The Commission has also issued a ruling re physician ownership of labs, offered to help the Medical Practice Board, and requested Blue Cross/Blue Shield of Michigan and other third parties to report any alleged wrongdoing by physician-members to component society ethics committees.

U.C. SAN FRANCISCO
MAY



For details on new MSMS building addition, see inside.

Construction to begin soon on new MSMS headquarters addition

Excavation will begin this month for construction of an addition to the MSMS headquarters building in East Lansing. The addition is to be ready for occupancy by January, 1979.

An early spring start is mandatory because (1) tenants desire to occupy at the earliest date, (2) a mortgage commitment had to be obtained before interest rates rise and (3) bids on construction had to be let before costs escalate.

Information about the addition is being reported by the MSMS House of Delegates Ways and Means Committee to the 11 councilor conferences being held now across the state.

MSMS will lease the second floor to a Michigan liability insurance company, which has outgrown its present quarters rented in East Lansing. A computer firm, the MSMS Office of Special Services and some MSMS personnel will occupy space on the first floor.

The addition will be connected by a walkway with the MSMS headquarters. Parking will be expanded to accommodate 170 cars. A landscape plan has been designed to save and replant as many as possible of the large trees now gracing the property.

The addition is the result of a study of future office needs initiated three years ago by the MSMS Board of Managers and carried out by The Council. The MSMS House of Delegates Ways and Means Committee has been continuously involved in developments and decisions.

The initial study projected MSMS requirements for the next 10-20 years and included preliminary drawings by Minoru Yamasaki, architect of the existing headquarters. The MSMS Finance Committee sought ways to most efficiently and effectively use the valuable MSMS property. The committee also investigated whether the office space planned would provide rental income to offset building costs. The study was financed with money from the MSMS Creative Reserve Fund.

A detailed report went to The Council which asked the study be continued, updated and reported back with recommendations in 1977.

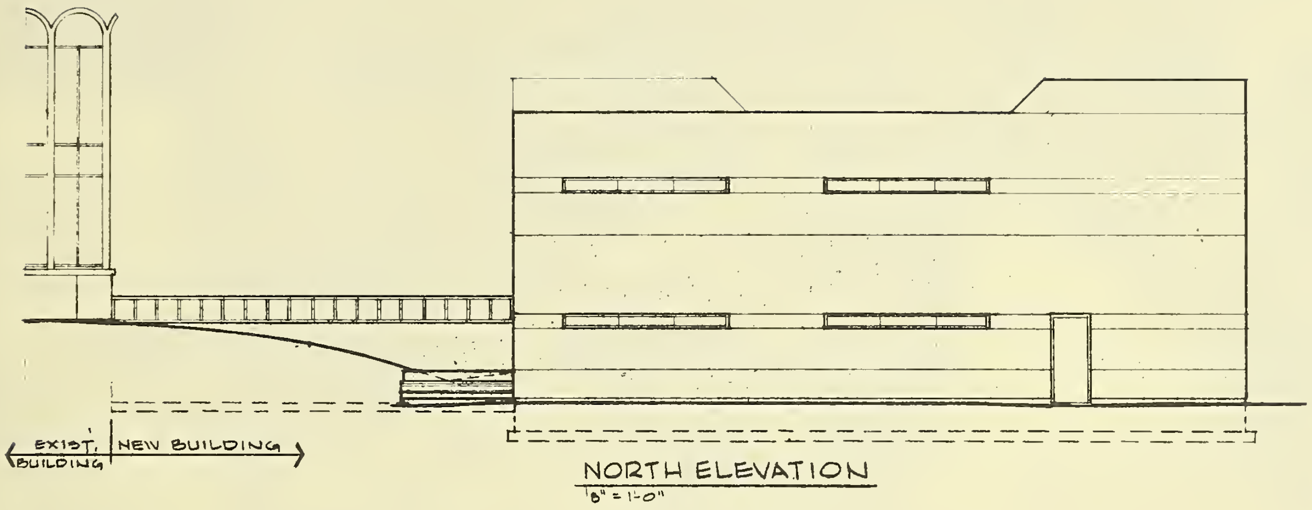
In 1977, the Board of Managers reviewed the report with The Council and the Ways and Means Committee and concluded: (1) MSMS activities had expanded so in three years there was need for immediate action, and (2) the most cost-effective building addition would be one that included space for lease to other, acceptable tenants.

The Council and the Ways and Means Committee concurred and the Board of Managers retained the architectural firm of O'Dell. Hewlett and Luchenback, Birmingham, MI, to prepare detailed recommendations regarding size, appearance, and location on the site within stated criteria.

The architects Sept. 6 recommended a two-story rectangular building, ranging in size from 15,000 to 25,000 square feet and requested a schematic design which was presented Dec. 5. The cost per square foot was estimated at $45-$48.

Lease costs were estimated and letters of intent to lease were secured. The House of Delegates Ways and Means Committee analyzed the potential impact construction would have on MSMS finances, and concluded financing and operating costs would be substantially offset by lease income. Thus impact on the MSMS budget would be minimal.

Following a final progress report to The Council in December, the Christman Company, Lansing, was selected as construction manager.



Architect's drawing gives good indication of how MSMS headquarters addition will look. At left is west corner of present MSMS building.

Connected by a walkway to the present building is the new, very functional addition. It will extend to the north. The MSMS headquarters, now being outgrown, was constructed in 1960.

MSMS Board of Managers, House Ways and Means members head building plans

Two MSMS groups which have been involved in the planning and fully informed of developments in the new building are the MSMS Board of Managers and the House of Delegates Ways and Means Committee.

The Board of Managers is responsible for overseeing the management of MSMS funds (Operating, Reserve and Creative Reserve). One of the purposes of the Creative Reserve is to finance planning of new enterprises or projects of benefit to the Society or the membership.

Its members are Leland E. Holly, II, MD, Muskegon; David Siegel, MD, Lansing; C. Allen Payne, MD, Grand Rapids; Arthur A. Ulmer, MD, Detroit; and John R. Ylvisaker, MD, Pontiac, chairman.

The Ways and Means Committee played a major part in the project and in determining the impact of the building costs on the MSMS budget. Members are Robert E. Paxton, MD, Fremont, chairman; James C. Danforth, Jr., MD, Grosse Pte. Woods; Hector J. Inchaustegui, MD, Royal Oak; Richard J. McMurray, MD, Flint; George Mogill, MD, Huntington Woods; Justin L. Sleight, MD, Lansing; Timothy M. Talbott, MD, Grand Rapids; Arthur A. Ulmer, MD, Grosse Pte. Shores.

ICDA, H-ICDA CODES REVISED

The present ICDA and H-ICDA diagnostic coding structures used by insurance companies are being combined and revised. The major change in the codes will be the addition of a Fifth digit which will further define the four-digit structure. As an example:

Current H-ICDA --

576.0 Cholangitis (includes)
  acute
  ascending
  chronic
  suppurative

Revised Structure --

576.0 Cholangitis
  576.01 acute
  576.02 ascending
  576.03 chronic
  576.04 suppurative

The revised coding structure is scheduled for introduction in January, 1979. Third party carriers are planning to supply physicians new manuals when the old manual becomes obsolete.

MSMS House May 5-7 to discuss varied resolutions

More than 50 resolutions have been received at MSMS headquarters from component medical societies in preparation for the 1978 MSMS House of Delegates meeting May 5-7 at the Hyatt Regency Dearborn. Deadline for the resolutions was April 5.

The resolutions cover a wide range of topics, including legislation, medical care cost control, HSAs PSROs and HMOs, ethics, Medicaid, Medicare, CME requirements and relationships with Blue Cross/Blue Shield.

Eight of the resolutions received by deadline deal with the Blues, four with the Michigan Physicians Mutual Liability Company, nine with state and federal legislation and five with health care costs.

Six reference committees will hold hearings on the resolutions and make recommendations for action on them by the full MSMS House of Delegates. Further information is available from Richard Campau at MSMS headquarters.

Practice management workshops scheduled in June by MSMS

Practicing physicians seeking better efficiency in office operations are invited to enroll in four practice management seminars planned in June by MSMS "Financial Control of Your Medical Practice" is the theme of the programs, scheduled June 6, 7, 8 and 9 in four locations around the state. Registration is $65. Locations are as follows: June 6--Wayne Count Medical Society headquarters, Detroit; June 7--Michigan Inn, Southfield; June 8--Longs Convention Center, Lansing; June 9--Holiday Inn, Traverse City. Contact John Richards at MSMS headquarters for information.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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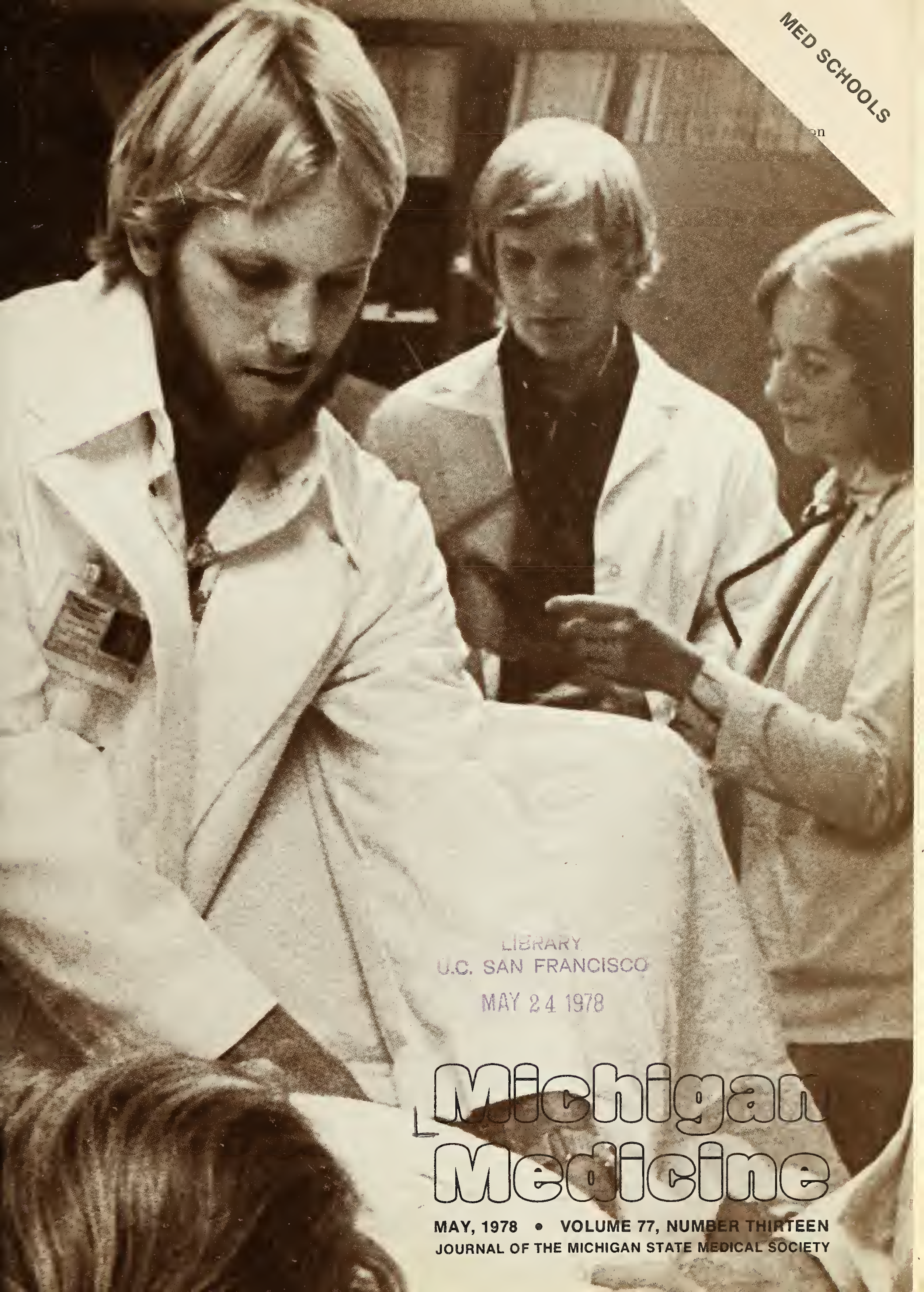

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Contents

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

MSU PHOTO

MSU medical school students learning examining techniques. Issues facing Michigan's medical schools today are discussed on pages 245-249.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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Medical schools caught by conflicting forces

By Ralph E. Lewis
Ann Arbor

Medical education and care are faced with complex issues when trying to apply social and technical knowledge to society's needs, wants, and demands.

Probably, this complexity is most acute and complicated in the field of medical education in the areas of recruitment and retention. Society demands more physicians, wants them distributed by specialty and geography so access is improved, and at the same time expects the cost of health care to be contained.

Although the number of medical schools, students enrolled, and students graduated has increased dramatically over the past decade, there still are imbalances in access to and cost of health care.

Over the past 10 years or so, the medical schools at the University of Michigan and Wayne State University have doubled their entering classes; a new College of Human Medicine was established at Michigan State University.

In 1977, 571 students were graduated from the three medical schools; this number will increase slightly in the next couple of years, then level off near 600.

First-year enrollment at the three schools currently stands near 600, and probably will remain there at least the next few years.

But to obtain these entering students, admissions committees screen nearly 10,000 applications. Many of these applicants apply to all three medical schools in the state, as well as to schools in other states.

The resulting problems facing admissions committees are enormous. They screen thousands of applications, interview hundreds of applicants, and attempt to satisfy not only the applicant but alumni, parents, faculty, community groups, legislators, even the federal government, as they make their selections.

How do you predict whether or not an applicant will successfully complete medical school and make a good physician? Where will he or she practice? Will he or she choose primary care? A specialty? Will he or she practice in a rural or urban area?

There has been a good deal of research in the effort to answer these questions, but generally there have been few conclusive results. Those results lack predictive power when we look at an individual student being admitted to medical school.

While cautious use by admissions committees of the information available can assist in selecting a particular kind of student, the current state of the art does not permit this data and knowledge to be used to project specialty or geographic distribution of physicians.

WSU medical school freshman orientation, September, 1977.

Barriers other than the competition still create problems for medical school aspirants. Financial barriers are not really a problem, although students, family, and counsellors think they are, and often result in students deciding not to apply.

Perhaps larger barriers are educational and attitudinal. Many high schools simply are not preparing graduates for medical school. Parents, counsellors and other professionals turn off many prospective applicants by the attitude that "you won't be accepted so what's the use trying." These attitudes are still especially prevalent as far as minorities and women are concerned.

Michigan's medical schools and their parent universities have vigorous recruitment programs. These efforts include outreach programs to all areas of the state, especially to rural and medically-underserved areas. Student medical associations and faculty regularly visit undergraduate colleges and universities.

Our Michigan medical schools have a good record in recruiting instate students. The efforts are paying off as more graduates select Michigan hospitals in which to do their graduate training, and also decide to practice in Michigan.

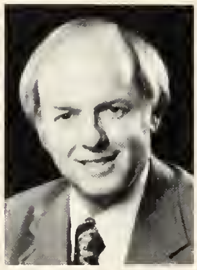
Michigan's medical schools, like those around the country, have responded to public demand and expectations for more physicians with increased enrollments and programs. As the demand for new programs and new services continues, financial resources, both state and federal, have become more limited.

A major problem facing us is how to continue to respond to these demands without compromising the high standards of medical education for which our state's medical schools have become famous and which the public expects and demands.

Mr. Lewis is executive director of the Michigan Medical Schools Council of Deans.

The challenge: qualifying for money without losing individuality

By John A. Gronvall, MD
Dean, The University of Michigan Medical School



Dean Gronvall

Along with others, The University of Michigan Medical School continues to experience the exciting, though at times frustrating, tension between public desires for new activities, and severe limits in the means to accomplish these desires. The funds to undertake new programs are limited or absent, and medical schools face the necessity of realigning existing support.

Further, as the proportion of medical school support from federal sources has increased, the schools are put at increasing risk of becoming mere extensions of the federal government. It may well be, then, that the most difficult challenge facing medical schools and teaching hospitals in the years ahead will be qualifying for badly needed federal dollars without allowing themselves to be transformed from centers of competence to colonies of compliance.

Federal controls

Medical schools' experience in relation to federal health manpower legislation is a case in point. While federal funds to directly support medical schools' educational programs actually are declining, the government wants increasing control over the entire curriculum. More specifically, the current act mandating transfer of US citizens from foreign medical schools demonstrates that with federal funds come federal control. It was only as a result of strong protests from medical schools and universities that in Dec., 1977, an amendment to the health manpower bill occurred. Medical schools still are required to admit such transfers, but the schools can use their own academic criteria as long as they demonstrate "good faith effort" has been made to accept the required number of transfers. Twelve such transfer students will be admitted to Michigan next Fall.

While working under such financial and governmental pressures strapping all medical schools, the U-M Medical School still manages growth of needed new facilities and programs.

New buildings

At present two buildings represent the kinds of physical plant problems threatening the quality of scholarly programs and clinical service at the U-M Medical School: the inadequate Medical Library and University Hospital's obsolete main unit. Replacing these structures is of paramount importance. Happily, success can be reported in the first case, and significant progress in the latter.

Ground-breaking ceremonies for the Taubman Medical Library were held in December. In obtaining funds for the new Library, we have a fine example of what can be accomplished when federal, state, and private donors work together. Of the $8,050,000 needed for construction, $4 million will come from state government, $2,550,000 from federal government, and $1.5 million from private gifts. The harsh realities of inflation and diminished support for medical schools make such pooling of monies the likely prototype for major projects of the future. As a condition of the federal grant, the medical school will increase its entering class by 12 students (from the present 237 freshman medical students to 249 in the Fall of 1980).

One can hardly exaggerate the administrative-bureaucratic complexities and sheer physical magnitude of replacing University Hospital's 50-year-old main unit. It will, in fact, be the largest single building project ever undertaken by the state. But there is no doubt the educational quality available at the U-M Medical School is irrevocably and directly linked to this project.

Last May, the Michigan Supreme Court upheld as constitutional a 1976 law authorizing the State to sell bonds to finance new construction, thus affording a solid means of funding for the Hospital replacement. Additionally, last August the University purchased the vacated St. Joseph Mercy Hospital plus 11.5 acres adjacent to both main and medical campuses. This additional land and the flexibility created through addition of these buildings will be important parts of the long-term replacement project.

Family Practice Department

Another major step at U-M Medical School has been taken through creation of a Department of Family Practice, headed by Terence C. Davies, MD. It is expected that the family practice residency will begin July, 1979. When fully implemented, the three-year program will have between 25-30 house officers. The patient care unit of the new department will be located at the Chelsea Clinic in Chelsea.

Wayne report reveals pressures on today's medical schools

By Robert D. Coye, MD
Dean, Wayne State University School of Medicine

Wayne State University's School of Medicine is deeply involved in the struggle to find new and better ways to provide top quality medical education and to meet commitments for new programs without the addition of large new investments of public money.

Wayne State's unique circumstances include freshman medical class growth from 165 students in 1969 to 256 at present.

In addition, the new University Clinics will be completed late this year or in early spring. But we will be unable to carry out all of the new programs planned for that facility until we can add substantially to our clinical faculty.

Public sentiment does not appear very strong in support of higher education right now; and, as a very expensive part of the higher education system, medicine is doing its share of biting the financial bullet. This is not done willingly or with very good grace by most of us, but must be recognized as a fact of life. We may regret, decry and raise sincere alarums, but there are really only two choices for us — to let the ship slowly sink or to struggle to find new ways to keep it afloat and on course.

WSU's view

Presentation of the factors of this struggle as we see them should help Michigan physicians better understand the pressures their Michigan medical schools work under today.

WSU has developed a position with respect to future operations of the school which we hope will put us on a more effective financial base. Deputy Dean Larry Weiner, PhD, summarized in a recent letter to the faculty: "We feel confident general belt-tightening will allow us to complete the 1977-78 year without incurring a deficit. However, no amount of 'fine-tuning' of the budget will make up the deficits predicted for 1978-79."

Dean Coye

"Before solutions can be considered, we must define the problem. To train 1,024 medical students, 600 house officers and 200 graduate students we require a faculty of approximately 500. We do not have that number now! We will have difficulty maintaining the 400 we now have! We must devise a mechanism to keep the 400 and to hire the additional 100.

"An obvious, but totally unsatisfactory, solution is to cut back on students until a match between students and available faculty is met. Why unsatisfactory? As we cut back on students, both the State and Federal agencies would cut back on our funding and we would gain nothing.

"It would be equally unsatisfactory and self-defeating to our major mission of teaching and research to suggest that we do without the additional faculty and require the present faculty to continue to 'take up the slack.' "

Two solutions

"Basically, there are only two ways to solve the problem:

"1. By cutting costs and increasing efficiency of current and future operations.

"2. By developing increased funding mechanisms.

"If we cut costs and increase efficiency of current and future operations, all administrative cost centers must be reevaluated.

"Is there 'fat' in these units which can be trimmed?

"Research personnel currently supported by the School must be shifted to 'other funds.'

"All academic units must be reevaluated from the following parameters:

"Is a program required essential, or only an adjunct to the primary goals of this School?

"Is the staffing pattern of the unit in relation to its teaching and service activities, and research support realistic?

"What proportion of the staff in *primarily* service programs should be supported as an academic expense?

"The School must support that number of faculty required for the teaching, service related teaching, and research activities of the unit. However, the unit must support the remaining service activities.

"If we develop increased funding mechanisms, the school and the University must do a better job of selling our needs for additional funding to the State.

"The school and its departments must increase grant and contract support with some faculty and all research personnel costs covered by the grant or contract.

"Foundation support must be sought for experimental academic programs.

"The Faculty Practice Plan must be implemented under the conditions and for the purposes expressed in the guideline document.

"Since the cost of educating a medical student far exceeds the tuition charged, the adoption of an additional fee schedule must be considered. A tuition increase would revert to the University. Fees remain within the School.

"These are not new or radically different approaches to attaining fiscal solvency. Rather, they are rational and sound, and provide a means by which we can continue the growth and development of this School and its programs."

These thoughts and views of how the Wayne Medical School may be able to grow do not guarantee a rosy future, nor do they help in making the difficult decisions as to which programs will have to contract. These views do provide a framework, and we hope a basis for belief that something can be done.

MSU med school concerned with Washington, progress on campus

By W. Donald Weston, MD
Dean, Michigan State University College of Human Medicine

The past two years have brought significant changes to the Michigan State University College of Human Medicine: A change in the deanship, the opening of a major new ambulatory care center on campus, and dramatic shifts in federal funding guidelines.

Nonetheless, the college has made important progress. And throughout, the extraordinary quality of the relationships between the medical school and its affiliated community hospitals and the invaluable contributions of its over 1,000 practicing volunteer faculty physicians to its clinical education programs, have provided continuity, cohesiveness, and stability.

This short report will touch on some major concerns and developments of the college today.

Washington's messages

There are clear messages from Washington that the nation's medical schools can expect regulations relating to federal funding to become progressively more restrictive over the next several years. Increased control by the federal government over the schools for which it provides dollars is inherent in much recent legislation. For example, residency programs affiliated with medical schools which receive federal capitation funds are required to have an increasing percentage of positions in primary care programs. Expanding federal requirements, while alarming, can also be viewed as logical, evolutional steps, which, given adequate time to prepare, can lead to responsive and dynamic acceptance by the State governments of the needs of institutions of higher learning in general, and medical schools in particular.

Dean Weston

MSU has, for the past several years, been placing increasing emphasis on the need for fiscal planning based on carefully-weighed programmatic evaluation. Long-range plans, reassessed annually, are required, and the College of Human Medicine has welcomed this realistic approach to financial accountability of public institutions.

Accreditation Visit

The AMA-AAMC Liaison Committee on Medical Education has scheduled an accreditation site visit to the College of Human Medicine in April, 1978. Intense preparation for this event, involving a really extraordinary faculty effort over many months, has culminated in a comprehensive self-study report. The faculty has weighed programs, policies, curriculum, and management of this medical school. Resulting from this effort has been a carefully-drafted Mission Statement of the school, which has the implicit approval of the entire faculty. Strengths and weaknesses have been identified and recommendations and strategies developed which can provide a clear direction to the school's administration over the next decade. We feel that the effort has been extremely important, and will have long-lasting impact on the school.

Medical humanities

The increasingly complex ethical problems faced by the medical profession and by society make it logical that MSU, with its major commitment to medical education, formalize its efforts in the medical humanities.

Established in the fall of 1977, the Program in Medical Humanities will facilitate the efforts of all members of the academic community interested in the interrelationships between medicine and the humanities. A number of current issues have emphasized the need for such interdisciplinary collaboration: life and death issues related to new knowledge and technology; conflicts between the interests of human experimental subjects and the advancement of medical knowledge; problems in the distribution of scarce medical resources, concerns for fairness in national health policy, and a general feeling of progressive dehumanization resulting from the emphasis on science and technology in modern medicine. Andrew D. Hunt, Jr., MD, the founding dean of the College of Human Medicine, has a longstanding commitment to a humanistic approach to medical education and health care. He heads up this new program. He brings wisdom, experience, humor, and compassion to this effort which, over time, could have profound implications for the lives of us all.

Clinical Center

The opening, in October, 1976, of the new Clinical Center, an on-campus ambulatory care center designed to provide health care to the public, has had a strong influence on the development of the College of Human Medicine. It provides an opportunity to teach medical students in an ambulatory setting, one of the principles inherent in the philosophy of the school since its inception. It has also, without altering the strong emphasis on clinical teaching programs in the outlying communities, allowed the College to study at first-hand the problems of cost containment and more effective and efficient methods of providing health care. It has, furthermore, given allopathic and osteopathic physicians a chance to work together in ways which may be unique in an educational institution in this country. There have been great achievements and great problems; both opportunity and challenge. But the Clinical Center at MSU is an arena for interaction between the professions which may be significant to the development of American medicine.

The MSU College of Human Medicine, which granted its first degrees in 1972, is an important experiment, not only in medical education but also in the effect of altered education on the social context of the health care system.

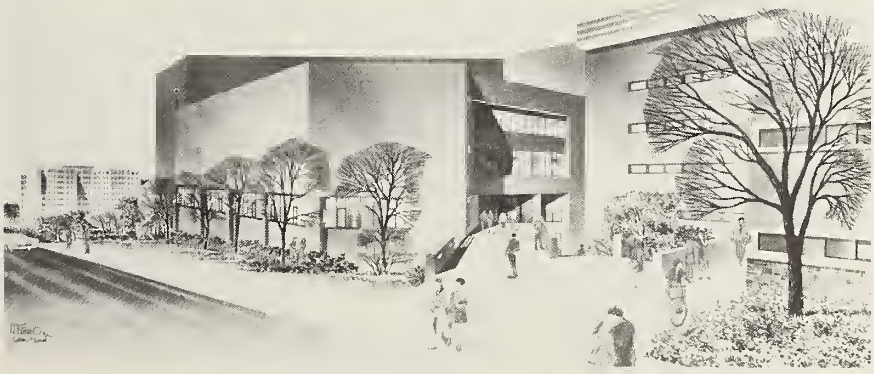
Admissions committees have enormous job

By Ralph E. Lewis
Ann Arbor

Because of the complex nature and the large numbers of applicants and applications involved, the admissions committees of Michigan's medical schools are large and broad-based. In 1977, for instance, the three medical schools screened nearly 10,000 applications for some 600 first year places.

Admissions committees of Michigan's three medical schools are composed of faculty members, from both the basic and clinical sciences, administrators, medical students, and practicing physicians. The committees assist office staffs in considering the acceptability of applicants by reviewing the required items that are submitted to the committee by all applicants.

MSU College of Human Medicine second-year student Judith Odenheimer, second from right, learns examining techniques. Instructing are, from left, pediatrician Thomas A. Helmrath, MD, associate dean of clinical programs and member of the CHM Department of Human Development; Robin Perlow, MD, third-year MSU pediatrics resident, and Brigid Warren, RN, MSN, clinical specialist and assistant professor in the MSU School of Nursing.



U-M's new Taubman Medical Library.

Mr. Lewis

Biographical information, college academic records, New Medical Colleges Admissions Test (New MCAT) scores, the applicant's personal comments, extra curricular activities, work record, letters of recommendation, and faculty evaluations receive major attention in the screening process.

Final admissions decisions are usually made by the admissions committee based on the above factors, plus a personal interview.

Future physicians

In making its selection from each year's group of applicants, admissions committees realize they are selecting future physicians. The admissions process, therefore, is an effort to select applicants possessed of those talents, skills, and interests which are requisite for the successful study and practice of medicine.

Personal interviews are held with all applicants seriously considered after original screening of credentials and application materials. This personal contact may afford the interviewer an opportunity to confirm reports already in hand, as well as to permit the candidate to give further support to his application.

All applicants are considered on the basis of individual qualifications. The academic record and New MCAT furnish an estimate of intellectual competence.

The less tangible qualities of character, personal fitness, and motivation are judged from reports of instructors, letters of recommendation, and the interview. No information that may help an admissions committee select those best suited to be doctors is irrelevant.

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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MSMS helps you to survive and have your voice heard as a responsible professional in an increasingly interdependent and socialized society.

Letters

". . . something will be done exactly the way politicians and bureaucracy wish . . ."

Regarding the recent letter in *Michigan Medicine* (Feb., 1978 by Hermann Ziel, MD, chief, Bureau of Health Care Administration, Michigan Department of Public Health), about hospital beds and related legislation:

The remark, "I do not believe there can be any legitimate question as to the very substantial surplus of beds in Michigan hospitals . . ." makes me feel that I must be illegitimate because I certainly do question there being a substantial surplus of beds. It is probably easy for the director of the health department, or the president of Blue Cross/Blue Shield, or a member of the executive board of the UAW, or a state senator or representative, or any other individual in a position of prestige and/or power, to secure admission to a hospital when they are ill. That is unfortunately not true of us lower-class citizens.

The fact there are at times a large number of empty beds in hospitals does not by any means indicate that those hospitals are overbedded, or the beds are "under-utilized." The question has to be, "How many people are we willing to let die because there are inadequate hospital facilities available during periods of high utilization, simply that we may contain the number of beds to suit the desires of the bureaucracy?" When I am ill and need care in a hospital by a physician, I do not want that hospital's representative to say to me, "I am sorry but we were overbedded and had to give up 10 percent of our beds, and this is a bad season of the year for us and we don't have any beds available, but if you'll take your heart attack back and come back next summer we will have room for you."

I think the final paragraph is perhaps the most eloquent. "It is imperative that physicians bear responsibility for correcting over- or under-utilization." The only question is whether each day we must call Lansing and find out whether we are overutilizing or underutilizing so we will know which corrective action to take. Of course, we will have to double-check this with the Food & Drug Administration in Washington, and also with the Department of Health, Education and Welfare at whatever level, and perhaps we would be best to have teletyped communication with all regulatory agencies so that we might check on what the bureaucracy thinks about what we are doing each day.

The remarks that the Michigan State Medical Society ignores these critical issues demonstrates an ignorance inconsistent with the author's responsibility as head of a state health department. I have been a

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member of the House of Delegates for over 10 years, and one would have to be blind and deaf to have attended any meetings of the House of Delegates in the last 10 years and not become fatigued by the discussions regarding physicians' responsibility for over and under utilization, and proposed solutions for the problem.

The final remark, of course, is the whole point, and I would quote, "On the other hand, it is likely that something will be done before long to resolve [the overutilization and overbedding issues] . . . with or without physician input." I think the author should have stressed that it will be done exactly the way the bureaucracy and the politicians wish no matter what the doctors or the other interested parties say, because the bureaucracy and the politicians are not interested in the facts, they are interested in the exercise of power.

It would be marvelous, indeed, if the members of the bureaucracy and the politicians would conduct themselves in the public's best interest as conscientiously as the vast majority of physicians and physician organizations, including the MSMS.

Clark B. Smith, MD
Hillsdale

"What is legal background for Blues' differentials?"

As I continue to read your informative *Michigan Medicine/Medigram* I become increasingly incensed at the arrogance of Blue Cross and Blue Shield. What provokes me the most is their ability to set differential fee scales between participating and non-participating physicians.

Could you provide the legal background that will allow for such a differential? This to me seems to be unjust, immoral, and illegal. I would very much appreciate being better informed as to the steps that allowed such a perverted system of justice to exist.

Harry W. Burdick, MD
Kalamazoo

MSMS legal counsel replies:

"We share your feeling that the fee differentials established by Blue Shield as between participating and non-participating doctors are indeed unfair, unreasonable and unsupportable for any medical or overall economic reason. The Blues seem to maintain that some such control is vital to their admitted need for cost containment. Moreover, and with respect to various specialty programs, the Blues maintain they are merely the third party administrators of programs worked out in labor negotiations between the motor companies and unions.

'Clearly such programs are factually discriminatory. Whether they are illegal is a question now pending in the courts. MSMS has litigation going in the Federal District Court at Detroit addressing this problem and the Texas pharmaceutical case is pending in the US Supreme Court.' "

(Continued on page 258)

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WJR's medical theme day a great success

By Mert Scholten, MSMS staff

Health tips, physician interviews, news items, answers to listeners' questions and physicians discussing great composers mixed March 23 to make Detroit radio station WJR's theme day "To your health" a delightful success.

Working with MSMS staff, Oscar Frenette, WJR director of public service, coordinated the day's activities aimed at getting listeners to take better care of their health.

Each WJR personality added his own particular touch during the day by offering spot announcements prepared with MSMS assistance, interviewing a physician or other healthcare specialist, handling calls from listeners or sharing their own experiences.

J.P. McCarthy, Detroit's best-known radio personality, carried on the theme day through phone conversations with Joseph Arends, MD, Troy specialist in aerospace medicine and preventive health and Gary Knapp, MD, Taylor family physician, on general fitness and the "physiology of the hangover" (at a listener's request).

WJR's appreciation

Thanks for all your help in planning what turned out to be a most successful "Theme Day" on WJR.

I particularly want to commend you on the posters you mailed out. That was something I had not expected and I know it contributed greatly to our advanced promotion.

Thanks again for your help and please extend WJR's appreciation to your members. The response to the day has been great.

Best regards
Oscar Frenette
WJR Director of Public Service

"To your health" callers and visitors were greeted by Pam Caldwell who serves as WJR receptionist and phone voice in the 21st floor Fisher Building offices of Michigan's most powerful radio station.

Early morning host and Detroit's best-known radio personality J. P. McCarthy gets theme day off to a fine start with interviews, health tips and comments about health. Here he checks a copy note prior to reading a health tip as he sits at the control panel. At the right is producer Hal Youngblood. Note the MSMS *Medigram* poster mounted on the studio wall above Youngblood.

Jimmy Launce, left, listens intently to Richard Gallucci, MD's explanation of a medical point during the morning Jimmy Launce Show. Doctor Gallucci spent the entire two hours in the studio with Jimmy discussing a variety of medical topics and talking with listeners who called the program to ask medical questions.

Arnold Weissler, MD, right, close personal friend of Karl Haas, hosted "Adventures in Great Music," for the first time the program has ever had a guest host. Mr. Haas, the regular host, participated in the program via phone from New York and the two discussed a number of great composers and how their music and lives intertwined with their health problems.

Marc Avery, left, chats with Doctor Joseph Beninson, Ford Hospital dermatologist about skin cancers and the need for early detection and treatment of any type of cancer. Doctor Beninson joined Avery's afternoon program for the first hour.

Warren Pierce, evening talk interview show host, did a number of interviews with a variety of medical specialists from across the country. He shared with his listeners a short health quiz prepared by MSMS and the AMA. He closed out the "To your health" theme day which had begun some 24 hours earlier with Jay Roberts who used a number of health tip items on the all night show prior to the "Morning Music Hall."

Doctor Knapp also was the principal guest on the noon "Focus" program when he talked about the family doctor and the growth of this specialty.

Newscasts during the day carried short interviews with Joan Stryker, MD, Hutzel Hospital gynecologist who discussed menopause and estrogen therapy.

On the mid-morning show host Jimmy Launce had as studio guest Richard Gallucci, MD, Dearborn family physician who answered listeners' questions and talked about a range of topics with the host.

Following the news and "Focus," Mike Whorf ran the historical account of the work of William Beaumont, MD and his research on the digestive system as the "Kaleidoscope" show's contribution to the theme day.

A genuine first occurred on the popular "Adventures in Great Music" program when, for the only time in the history of the program, regular host Karl Haas turned over duties to his close friend Arnold Weissler, MD, Chairman, WSU, Department of Internal Medicine, and musicologist. Doctor Weissler hosted the program from the studio and spoke with Haas via phone from New York. The two discussed composers like DeBussy, Beethoven and others who worked under severe health conditions or who continued composing very late into life.

Afternoon "drive-time" personality Marc Avery had as his guest Joseph Beninson, MD, Ford Hospital dermatologist who talked with Marc about skin cancers, with particular emphasis on seeking early treatment. Avery shared some personal experiences he recently had with an unusual growth highly amenable to removal and cure if detected early enough.

On the evening program, talk host Warren Pierce offered a short health quiz prepared by MSMS in cooperation with the AMA and conducted a series of interviews with doctors and health personnel on topics ranging from "natural" childbirth to hyperactive children, diet, and what it's like to be medical advisor to television programs like MASH, "Dr. Kildare" and others.

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Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus*.

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

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There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of non-susceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

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'Public leaders have not made one step to help people understand costs of care demanded'

It is important for progress in the economics and in the science of medical care that consumer and provider have a dialogue. I appreciate Paul Massaron's taking the time to give us his version of what labor sees as physician accountability. ("Labor sees two goals: one is physician accountability," page 76, February, 1977, *Michigan Medicine*.)

I have some comments about the points he has made, however.

Regarding his statement that consumers do not admit themselves to the hospital or arrange for their discharge nor do they decide to stay in the hospital for an inordinate amount of time — might I offer some comments.

It is true the actual physical process of admission cannot be done by the patient. However, a patient determined to become admitted to the hospital can do so and I have seen it on many occasions. Older people with minor fractures are brought to the hospital, to the emergency room, where the hospital-based emergency room personnel will not turn the patient away because of severe and very often unpleasant pressure by the patient's relatives. Sometimes the patient has no place to go or no one to care for them, or sometimes the family is just too callous or busy to care for the older patient. As more and more physicians come on the scene and competition amongst physicians increases, we will see this type of hospital admission will probably be on the increase. Because, if I do not admit such a patient, they can go right around the corner and find someone who will.

Consumers *do* decide to stay in the hospital for inordinate amounts of time, and I actually have had to discharge patients from my practice because they would not leave the hospital stating "my insurance pays for it" or "Medicare pays for it." I have had many instances of unpleasantness, particularly with older patients over this fact. Blue Cross particularly has led patients to believe they are fully covered as has our government and the politicians that run it. These people are forever telling patients (and you must remember the old days of the Medicare battles) that their medical care will be paid for. This has been done over and over to the point where people believe they have it coming. This is the direct fault of our demagogic policies in the health care field in the national government and I am afraid people in the labor unions have been right up there in the front as far as promoting this. In a sense, they are reaping what they have sown.

Consumers do not write prescriptions for themselves. Very true. I write the prescription and I will write the prescription which I deem proper. I will very often deliberately not write a generic drug inasmuch as it is a copy of a drug which was developed by a company which is entitled to market that drug at a fair price in return for the trouble it has gone to develop it. I will have no part of cheap substitutes for my patients.

Consumers do not order an array of unnecessary tests and services for themselves. I guess the question there is "unnecessary." What may be necessary to diagnose one disease may be unnecessary in diagnosing another, though we do not know what is necessary or unnecessary until we are pretty sure what disease the patient has. And too, there are some tests that are necessary to protect my skin. Our litigious climate has produced such an atmosphere that I must be protected by making sure that all bets are covered. This may mean tests I feel are not necessary but which I know I would be hard put to defend my not ordering if I were in court being sued. Thus, they *will* be ordered, and the patient *will* pay for them.

Consumers do not decide to build unnecessary hospital beds. This is directly and absolutely not true. Consumers are represented by the board of trustees of the hospitals and in many instances (and particularly in one in my area), hospitals have been kept open because of pressure from the local citizens. Doctors are not at fault here, sir.

Consumers do not decide to keep beds on line that should be closed down. This is an interesting statement because the key word here is "should." There is a great deal of arrogance in the medical planning field these days in some people who purport to know what "should be done." Very often beds which are needed one week are not needed the next week and there is a great deal of fluctuation in season and due to economics in utilization of hospital beds.

Consumers do permit the continued existence of hospitals that should be closed. And again, who says they should be closed? In our area we have one that someone in government said should be closed but the local citizens decided should be kept open. It is open, it is viable, it is functioning and serving the community.

Consumers do not decide to acquire additional expensive equipment already available within the

(Continued on page 260)

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*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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community. This may be Mr. Massaron's strongest point. Very often doctors push for the latest in equipment. But again, doctors are motivated not so much by cost control but by the effort to save lives, minimize disability, get people back to productive and happy lives in as short a time as possible. There is a price tag on this, sir, and the general public is going to have to decide how much of a price tag it is willing to pay. If it wants to cut quality, it can do so.

The final solution rests in cooperation.

Mr. Massaron's union, which has pressed so hard for first dollar benefits in a demagogic ploy, could help a great deal by attempting to educate its members that "free" anything is not really free. There is a price tag, and members of society are going to have to decide how much society is willing to pay, whether it be for care of the aged, for care of "crunch jobs" due to motorcycle accidents, for alcoholism, or for tobacco consumption. Trying to make physicians the scapegoats for financial failure of expensive plans promulgated by the democratic leadership and the union leadership is not fair and eventually will not succeed.

We physicians are genuinely interested in seeing our patients get healthy and return to happy and productive lives rapidly. We are frustrated and dismayed by the "pie in the sky" promises of those who say all this can be accomplished at no expense or cheaper, or with cost controls, etc., etc. without sacrificing quality.

You can't do it on an automobile line and you can't do it in medicine and you can't do it on the farm. One has to decide how much of what one wants and in this case it is the consuming public that is going to have to make the decision. So far, the public has decided they want all of everything with no holds barred. Their leaders in the public arena have not made one step to help them understand the costs involved in this type of inordinate demand on the nation's resources. The medical profession is willing to help.

J. L. Kihm, MD
Kalamazoo

Mortality statistics clarified

The statistics about the "Major Causes of Death in Michigan in 1976" is printed on this page to correct several errors made in an article that appeared in the January issue of *Michigan Medicine.*

By studying the statistics, the reader will find — as is pointed out by Paul M. Lamb, unit manager, administrative procedures unit, State Department of Mental Health:

"As a percentage of the total, death among Michigan residents, younger than 55, is highest for homicides, suicides and accidents.

"While heart disease accounts for a majority of deaths in both age groups shown, for ages younger than 55 it represents only nine percent of the total."

Michigan Medicine incorrectly stated in the January issue that the top three causes of death for ages younger than 55 were homicide, accidents and suicides, in that order. Those three causes led in percentages only and not in numbers of deaths. In that age group, the table shows that heart with 2,724 deaths, malignant neoplasms with 2,712 and accidents with 2,647 led the list in number of deaths.

Major Causes of Death in Michigan in 1976

CAUSE	TOTAL DEATHS	% OF TOTAL DEATHS	TOTAL DEATHS AGES 55 AND OVER Number & %		TOTAL DEATHS UNDER AGE 55 Number & %	
Heart	29,233	38.6%	26,509	91%	2,724	9%
Myocardial Infarctian					1,545	
Chranic Eschemic Heart Disease					723	
Symptomatic Heart Disease					154	
Malignant Neoplasms	14,880	19.6%	12,168	72%	2,712	18%
Trachea Branchas Lung					612	
Breast					368	
Large Intestine, except rectum					172	
Leukema (Lymphatic, Myelaid, Manocytic)					171	
Brain					137	
Cervix-Uterus					120	
Cerebrovascular	7,354	9.7%	6,819	93%	535	7%
Accident	3,912	5.2%	1,265	32%	2,647	68%
Matar Vehicle					1,624	
Influenza-Pneumonia	2,106	2.8%	1,832	87%	274	13%
Diabetes Mellitus	1,719	2.3%	1,548	90%	171	10%
Cirrhosis of Liver	1,486	2.0%	828	56%	658	44%
Arteriosclerosis	1,207	1.6%	1,198	99%	9	1%
Suicide	1,182	1.6%	316	27%	866	73%
Homicide	1,092	1.4%	146	14%	946	86%
Emphysema	759	1.0%	715	94%	44	6%
	64,930		53,344		11,586	

TOTAL DEATHS IN MICHIGAN FROM ALL CAUSES, INCLUDING ABOVE, IS 75,801

Prepared by MSMS Department of Physician Education-Communications-Public Service, based on information compiled and supplied by the Office of Vital and Health Statistics of the Michigan Department of Public Health.

ADDENDUM

Co-author of the article, "We should study problems of child abuse reporting," page 138, March 1978 *Michigan Medicine,* was Frederica Lombard, PhD, Detroit. Her name was inadvertently omitted from the credits. Doctor Lombard is professor of law at Wayne State University Law School. She holds AB, JD and LLM degrees.

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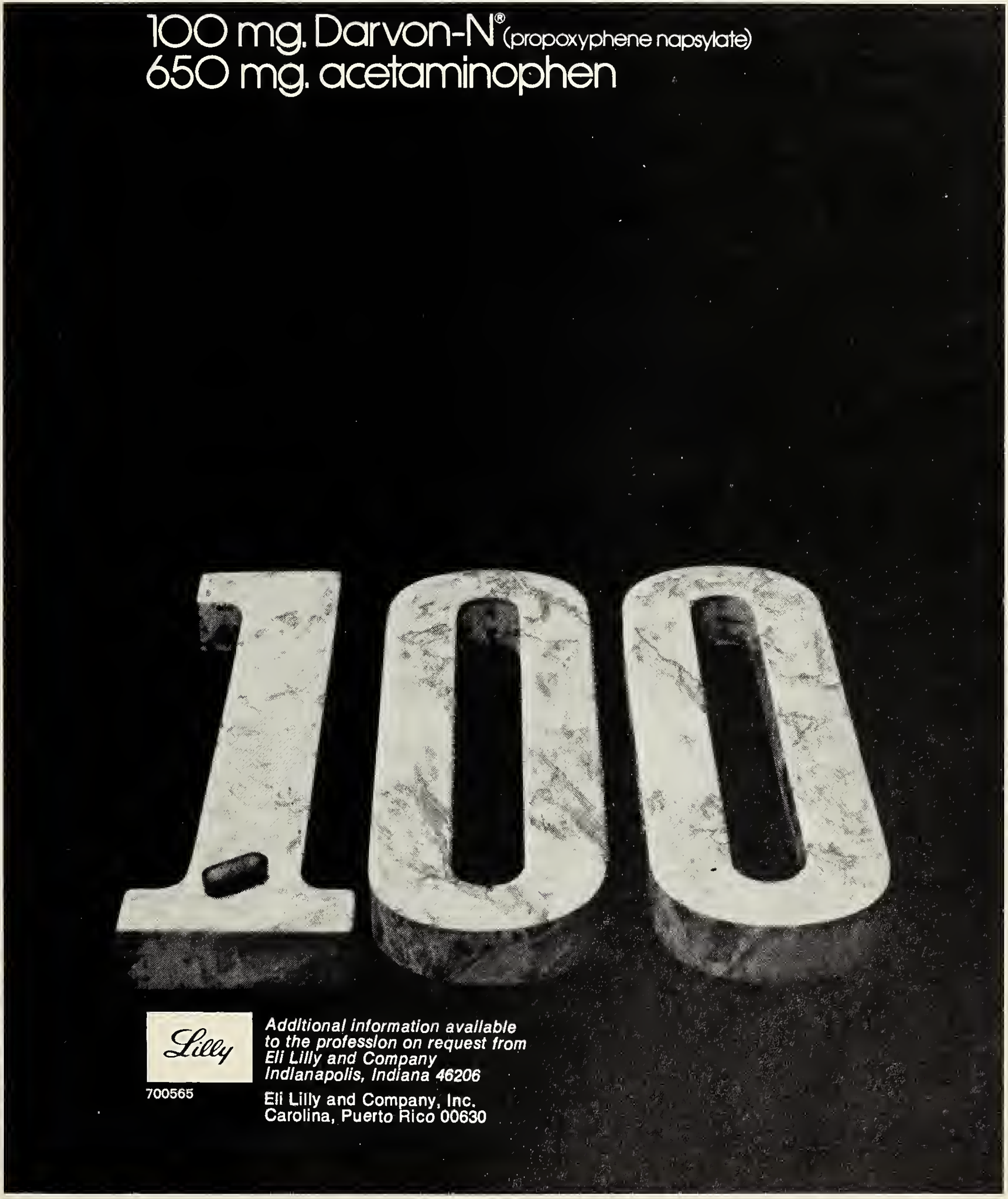

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"...Sleep that knits up the ravell'd sleave of care..."
—WILLIAM SHAKESPEARE, MACBETH, ACT II, SC. 2

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.[1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

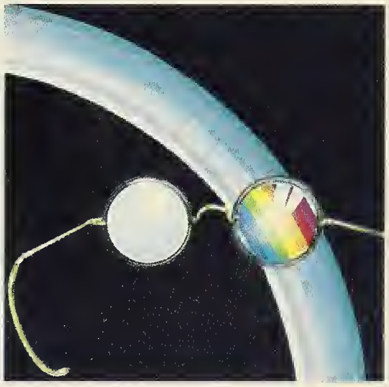
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



When they see life
in shades of blue...
help them see life
in all its colors.

Adapin®
(doxepin HCl)

single daily dose recommended h.s.

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18-357
18-358
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10 mg capsules
25 mg capsules
50 mg capsules
NEW 100 mg capsules

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The AMA Computer Systems in Medicine Consultative Services Program

The American Medical Association recognizes the potential that computers have in the health care setting. Therefore, the AMA has initiated the **Computer Systems in Medicine Consultative Services Program.** Through this program, physicians who are considering computer services as well as current users who want to improve or expand their computer applications can obtain an objective viewpoint and expertise in methods and equipment.

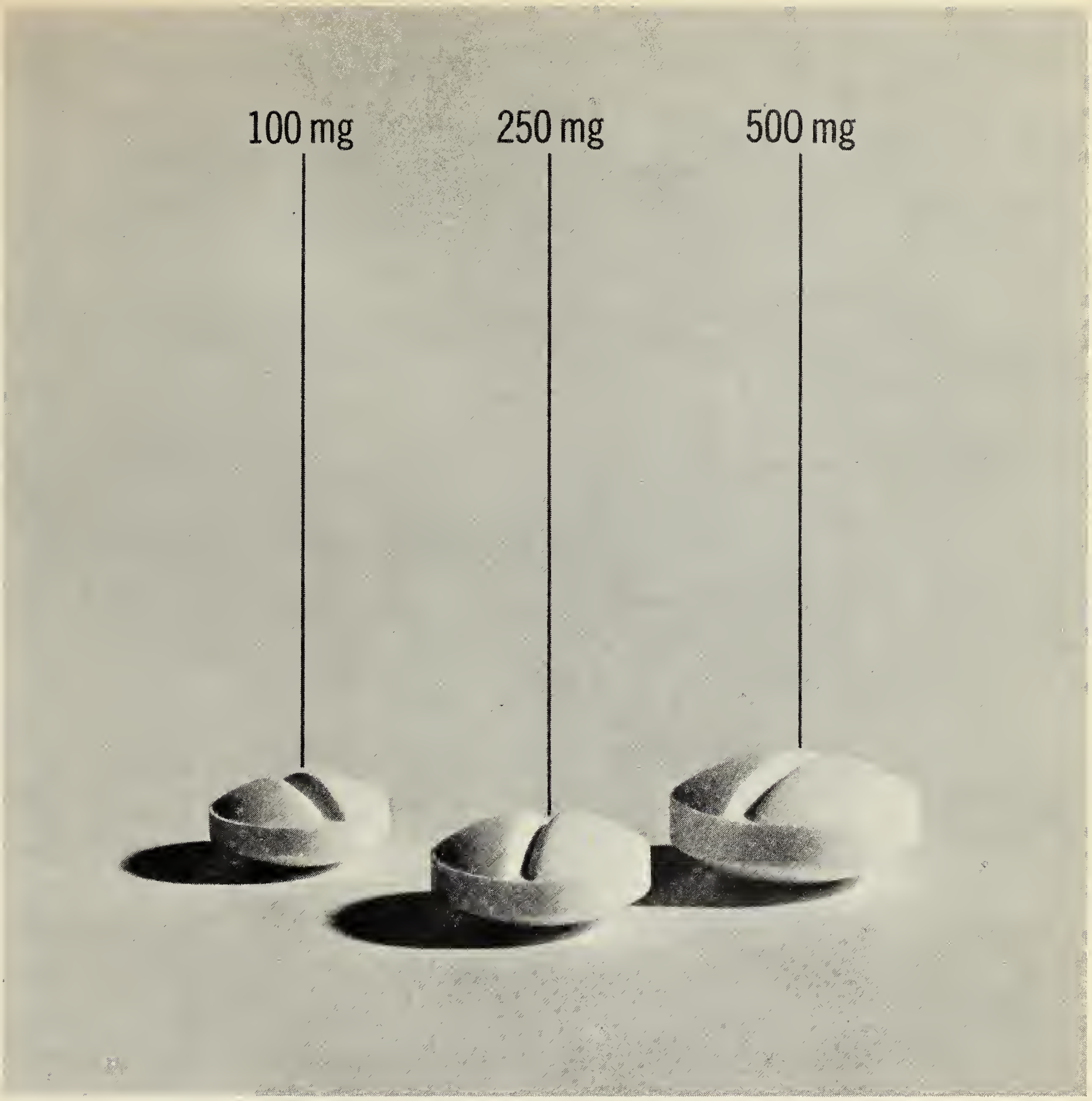
Computers have the potential to be a tremendous asset to the medical community, and have possible application in some or all of the following:

- Improving patient care
- Creating more accessible medical records
- Improving financial management and control
- Reducing the rate of increasing costs
- Improving facility and personnel utilization

The **Consultative Services Program** has established expertise extending from general decision-making on the utilization of computers in medicine to detailed systems design, programming and implementation of systems. The Program's activities include: needs analysis; alternatives development; specifications development; proposal evaluation; and systems audits.

While the major thrust of the **Consultative Services Program** will result from interest in the use of computers or computer-related services, the primary goal of the consultant is to recommend the most advantageous treatment of each situation. **The focus is the needs and objectives of the client,** not the promotion of computerized solutions.

For a more detailed description of this new and valuable service or to arrange a consultative visit, contact: John A. Guerrieri, Jr., Program Director, Consultative Services Program, at (312) 751-6417.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250 mg
500 mg

Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

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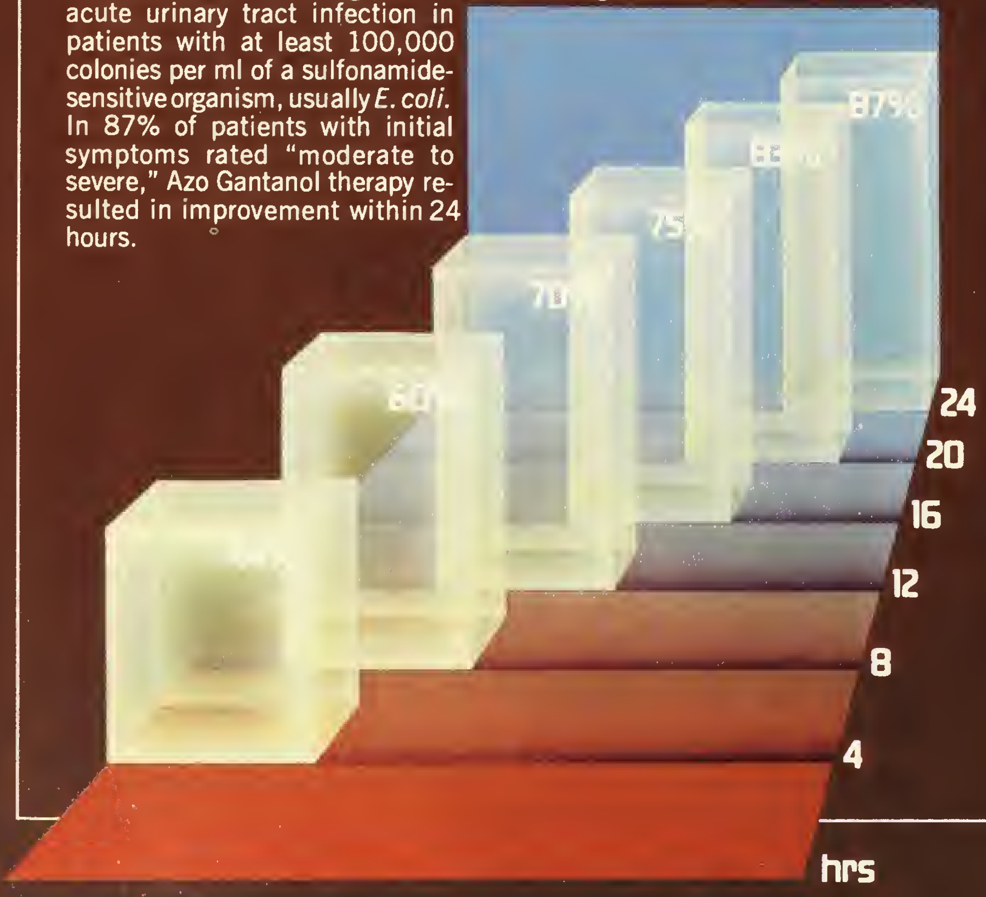
Important data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain **for the pathogens**

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

Before prescribing, please consult complete pro uct information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organism (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Ca fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; ad aminobenzoic acid to follow-up culture media. T increasing frequency of resistant organisms limi the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term an during nursing period; because Azo Gantanol co tains phenazopyridine hydrochloride it is contra dicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G. disturbances.

Warnings: Safety during pregnancy not establish Deaths from hypersensitivity reactions, agranulo tosis, aplastic anemia and other blood dyscrasia have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may in dicate serious blood disorders. Frequent CBC ar urinalysis with microscopic examination are rec ommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypopr thrombinemia and methemoglobinemia); *allerg reactions* (erythema multiforme, skin eruptions Stevens-Johnson syndrome, epidermal necrolys urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, phot sensitization, arthralgia and allergic myocarditi *G.I. reactions* (nausea, emesis, abdominal pair hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripher neuritis, mental depression, convulsions, ataxi hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxi nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hyp glycemic agents, sulfonamides have caused ra instances of goiter production, diuresis and hy glycemia. Cross-sensitivity with these agents m exist.

Dosage: Azo Gantanol is intended for the acute painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 G (2 tabs) B.I.D. for up to 3 days. If pain persist causes other than infection should be sought. After relief of pain has been obtained, continu treatment with Gantanol (sulfamethoxazole) m be considered.

NOTE: Patients should be told that the orange dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each cont ing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche
Nutley, New Jersey 07110

Much closer cooperation needed to improve care of elderly

By Charles W. Shipman, MD
Traverse City

If the Michigan State Medical Society CME Committee is to address itself to the massive problem of better care for the elderly in Michigan, there are a few factors including the general attributes of the elderly that seem important to me. There are probably as many ways of addressing the problem as the elderly have problems.

The committee should be as concerned with the kind and amount of training given to physicians training in medical schools as they are concerned about post-graduate training for practicing physicians. It is probable that more courses in gerontology as well as more experience in the actual clinical supervision of elderly people would be necessary. One university school in Wisconsin, for example, has medical students regularly visiting and giving direct patient care in nursing homes for a specific number of weeks. Family practitioners in training must follow a certain number of patients in a similar setting for at least a year.

Diagnosis, treatment complex

The five general attributes of the geriatric population which make diagnosis and treatment for this age group one of the most complex and sometimes frustrating tasks in medicine are:

a) The elderly generally show diminution of physiological capacities in many different ways and in all organ systems in the body.

b) Typical signs and symptoms of disease; such as, temperature elevation and/or pain may be absent, attenuated or delayed.

c) The effects of drugs in the elderly are much greater and so is the potential for adverse reactions and inter-reactions. There appears to be a lack of knowledge about psychopharmacology, pharmacology and pharmacokinetics in those physicians' records that I have been privileged to review.

d) Physical disease often presents as mental disorder which is the acute brain syndrome.

e) The elderly usually have multiple clinical and other problems, and these bear on the potentials of and approaches to therapy.

There should be many more courses available for practicing physicians to become knowledgable about the physiological changes that occur with aging and what effect these changes have on drugs that the patient might be taking. For example, liver disease such as chronic gall bladder disease may change the physiological ability of the liver to metabolize drugs. Yet, approximately one in 14 of the elderly people have some type of liver disease.

Comprehensive courses on drug prescribing for the elderly with special emphasis on the use and abuse of drugs for the control of deviant behavior in nursing homes is badly needed.

Drug evaluation needed

An interesting evaluation would be the impact on physicians' prescribing habits by a) drug companies' advertising materials and b) drug companies' regularly-visiting detail salesmen. "Rumor" has it that currently, drug companies are spending close to $7,000 annually on each physician to encourage the sales of their particular drugs. The dangers of side effects are usually minimized in small print in the PDR or the handout but the possibly beneficial effects are usually very glowing and complimentary to the drugs to be sold.

Doctor Shipman

Much closer cooperation is needed possibly to the degree of a joint adventure with other groups currently concerned about the care of the elderly, especially nursing homes, such as 1) Senator John Otterbacher and his group, 2) the special committee appointed by Governor Milliken to investigate substance abuse by the elderly and 3) the Office of the Aging and 4) the Michigan Department of Mental Health.

Possibly a series of articles, maybe even monthly, should be published in the *Michigan Medicine* and *Medigram* focusing on care of the elderly in Michigan.

Doctor Shipman is a leader of the MSMS CME Task Force to Improve Care of the Elderly.

Blues continuing tactics used since birth, despite MDs' objections

Doctor Meier

By Harold J. Meier, MD
Coldwater

Out of the financial woes of the depression came a poorly conceived plan to give aid and comfort to physicians and patients.

The age-long practice of the doctor being the last to be paid had deteriorated to no payments in many or nearly a majority of the cases. The need for a system to supply a reservoir of money to correct this inequity seemed obvious. Plans to develop a funding program were set in motion.

The approach was to allow people to set aside and accumulate funds for their health care which would be used for major illnesses. It was assumed consumers could pay for minor ailments themselves on a current basis. It also was to be of great benefit to physicians to have such a fund that could be drawn upon to pay doctors and hospitals with their nursing staffs and ancillary services.

Health insurance originals

Why not a health insurance system? Established commercial insurance companies dealing with life and fire were reluctant to enter the field because there were no statistics or actuarial studies to work from — such as how many persons would use the system on a yearly basis.

So physicians and hospitals decided they could organize their own program. They would underwrite it and guarantee a stipulated kind and amount of health care even if funds became depleted because of excessive and unforeseen use of health care. (This did happen and payments were pro-rated on a couple of occasions and delays in payments were used to carry on the program in other instances.)

This concept was built into an enabling act and Michigan Medical Service and Michigan Hospital Service became a reality. They later became Blue Shield and Blue Cross, respectively.

There was general acceptance of the program but there were doubts about the service guarantee and how services could be or might be manipulated in the future. There also were doubts as to the desirability of having a reimbursement system with management paying physician and hospital directly. This was contrary to the indemnity principle which was the pattern of the insurance industry to this time. Under the plan, the individual consumer would have no control over the funds, particularly the amount that was being spent on the service he/she was receiving.

The service contract carried with it a fee-for-service principle rather than a recovery from the fund in amounts consistent with an actuarial experience. The fee-for-service concept was to plague physicians and hospitals as time went on. The whole health care system was to develop third party control of the funds and to a great extent control of the type of service, both of which became bargaining units by special groups in the consumer community.

Physicians defaulted early

This chain of events was helped along by default in physician ranks. The doctors' control over third parties passed to consumers and an unhappy situation developed.

Only recently have physicians and hospitals made an attempt to re-insert themselves into the program with an ultimatum designed to correct some recent mistakes and perhaps even to correct the original mistakes made at the beginning.

It was inevitable that dissatisfaction would arise when the service concept was applied. The acceleration of this dissatisfaction came about when providers let third parties become heavily weighted with consumers and let management encroach on the basic physician-patient relationship. Union bargaining and participation by group enrollment practices were catalysts to third party control.

There were spokesmen in the medical profession who sounded words of warning at the very start, that the service principle and the reimbursement methods would eventually become tools with which a national health insurance program could be effected. (The threat of socialized medicine with the Murray-Wagner-Dingell bill was debated across the country during this period.)

The most ominous difficulty in the reimbursement plan was first-dollar-coverage. It led to exorbitant utilization by the consumers who rushed to use the services and who could not care less what was being charged as long as it was not coming out of their

(Continued on page 270)

Doctor Meier is former chairman of the MSMS Council.

This counselor earns his keep from helping your investments grow. Not from how much he sells.

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Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the Five-week Period Ending Mar. 31, 1978

	1978 This 5-Week Period	1977 Same 5-Week Period	1978 Total To Above Date	1977 Total Same Date	Total Cases for 1977
Rubella	294	257	653	432	1,160
Cong. Rubella Syndrome	0	0	0	0	3
Measles	738	282	1,644	489	1,392
Whooping Cough	1	4	6	7	73
Diphtheria	0	0	0	0	0
Mumps	221	390	604	876	2,339
Scarlet Fever & Strep Sore Throat	4,430	4,948	10,690	10,987	31,047
Tetanus	0	0	0	0	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	197	290	510	808	2,686
Salmonellosis (other than S. typhi)	71	63	229	225	989
Typhoid Fever (S. typhi)	1	2	3	6	13
Shigellosis	19	23	46	100	352
Aseptic Meningitis	7	6	23	21	207
Encephalitis	4	0	17	8	59
Meningococcic Meningitis	13	7	27	13	51
H. Influenzae Meningitis	7	6	24	31	151
Tuberculosis	126	160	261	376	1,279
Syphilis	122	131	257	307	1,151
Gonorrhea	3,023	2,968	7,602	7,746	36,883

Information can be supplied by the local health department on local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

VIEWS/*continued*

pockets. Ill-advised advertising by third parties fostered this run on the funds.

Likewise free access to funds by physicians and hospitals defied the nature of the human race with their tendency to misinterpret the inherent urge of self preservation.

Reasons for rising costs

Tied to dollar pay-out methods are many reasons for the ever-increasing cost of health care.

There are those who will argue that health care would never have attained such innovations, sophistication and high degree in medical technology had it not been for these "free-wheeling" health plans. Concession to this argument does not excuse the exploitation that has occurred under the system.

Yes, the birth of the Blues was heralded by many and condemned by some. The insurance industry at the time looked askance. They have since more or less fallen into line but have shunned first-dollar coverage and have used the service principle as a guide only to pay-outs on an indemnity principle to a great extent.

I believe a person should be the master of his own financial destiny and put his money in a pot or fund that is subject to pay-outs that come under the scrutiny of individuals, not computers. Two people face-to-face (physician and patient) will have checks and balances that have to be dealt with in the transaction. Eliminating the intermediary (third parties, agents) would put back into the economy the personal factors of integrity and the right of the consumer to have a voice in his own transactions with providers. This is the gut issue in the indemnity type of protection as opposed to the service contract principle.

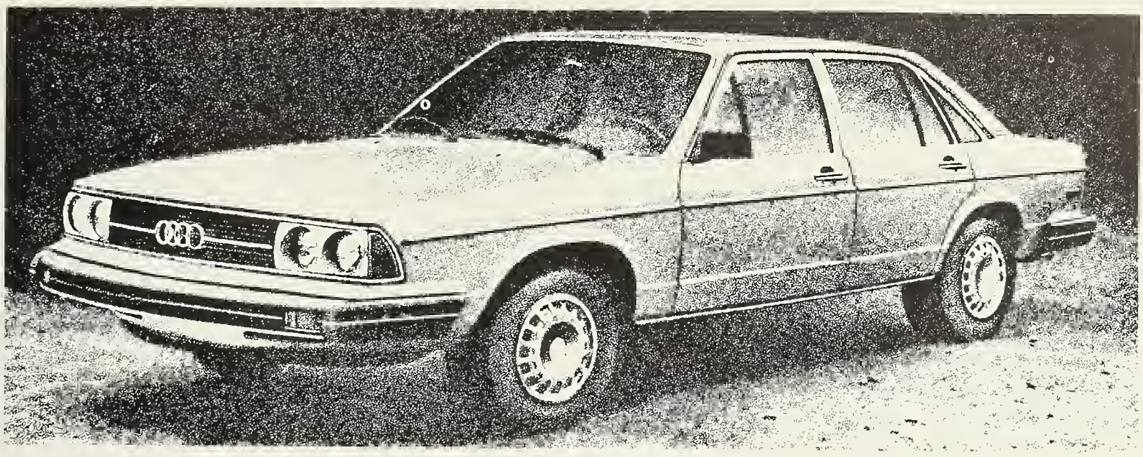
The Blues have become middle-aged now and a Gordian knot has been tied around their package. One segment of the knot is comprised of physicians' fear, (even though they may not like the direct payment practice from the Blues) that too large a percentage of the people (patients) would keep and use the medical payment coming to them for something else in their budget. The other part of the knot is that the patient-consumer has great fear to be without Blue Shield and Blue Cross coverage because of the rising costs of health care today, which can be financially difficult. What a shame the consumer has not opted for catastrophic instead of first-dollar, coverage.

This package so firmly tied with this Gordian knot is full of inequities and errors in medical-economic judgment. Mistakes include the requirement of hospitalization before some of the services become benefits.

I am sure the Blues will continue to operate along athe same lines as in the past, despite recent objections by MSMS.

I am also sure that the insurance industry could sit down and with the benefit of hindsight fashion a health care system that would be much more satisfactory than what we now have.

I am equally sure that socialized medicine is not the answer because it will be more costly, the incentives will be ruined, and the whole program will be bogged down with bureaucracy.



"WHEN YOU TEST-DRIVE THE AUDI 5000, SAVE IT FOR A RAINY DAY."

AN INTERVIEW WITH DR. FRANZ BEHLES, ASSISTANT AUDI PROJECT DIRECTOR

Why on a rainy day? Behles: In bad conditions, this car shows how good a car can really be. In good weather, nearly every car is good. But in rain, ice, snow or a strong crosswind, it's a different story. That's the time to try the Audi 5000. If you've never driven a front-wheel drive car on a slippery road, you're in for a surprise. The engine over the drive wheels gives excellent traction on rain, ice or snow.

Does everything depend on front-wheel drive? Behles: No. But front-wheel drive provides so many advantages that even in the U. S. engineers are using it in their "cars of the future." It's amusing to us since our company has been using this system for over forty years.

You sound very proud of this car. What are you proudest of? Behles: Our 5-cylinder gasoline engine; it's a first. We have achieved the best of both worlds: efficiency like a 4 and smoothness like a 6. And without excess noise or bulk.

You mentioned U.S. engineers. Would you hire a Detroit engineer? Behles: Yes, for some things; electronics for example. Cruise control borrowed from America. But we have it, as standard equipment. Also, we admired American air-conditioning; we developed ours based on one of their best systems. We can always learn from others, but I think our philosophies are different.

Different philosophies? Behles: Yes. Many Americans feel that for a car to hold the road well and be comfortable, it has to be heavy. We feel that weight is wasteful. We can achieve the same degree of road holding, comfort and safety through advanced engineering.

If you could start over again, would you do anything different? Behles: I don't know what. There would be no sense in making it bigger. The interior and trunk are big enough. It is already the biggest German car you can buy for the money, (about $8,500*). More power? The 5-cylinder engine gives you more power than you need.

*Suggested 1978 retail price $8450, P.O.E., transp., local taxes, and dealer delivery charges, additional

See your nearby Audi dealer.

Here is second MSMS report on Michigan medical malpractice claims

By John A. Richards, Chief
MSMS Bureau of Economics

This is the second in a series of reports on closed malpractice claims compiled by the MSMS Bureau of Economics. These tables were prepared from cases closed between March, 1977 and November, 1977. During this period 290 separate cases were settled. This represents the total number of cases which completed the legal process, rather than the total number of incidents. Many claims were reported separately due to the fact they were actions brought against individual practitioners which arose from the same incident.

Certain information from our first survey has been deleted due to concerns with recent legislation on individual rights to privacy.

The first report included data on 522 cases settled for all years up to March, 1977. While this report represents little more than half the number of cases, the percentages and distribution show little change. Large variation in any one category may be attributed to sample size and may not indicate any significant trend. You may note, however, that since our last report total indemnities paid by insurance companies seem to be increasing.

Great caution must be taken in interpreting the results of this survey. Only the most preliminary conclusions can be drawn from this data, due to the short time period covered and the relatively small number of cases examined to date. Technical in-

	As of March, 1977		March-November 1977	
1. County:				
Wayne	217	40.0%	109	39.2%
Oakland	61	11.2	49	17.6
Macomb	30	5.5	14	5.0
Genesee	25	4.6	14	5.0
Washtenaw	22	4.1	11	4.0
Upper Peninsula	8	1.5	9	3.2
Other counties	180	33.1	72	25.9
	543	100.0%	278	99.9%
2. Type of Practice:				
Institution	17	3.2%	2	.7%
P.C. or partnership	121	22.8	32	11.1
Self-employed	373	70.4	240	83.0
Employed MD	19	3.6	15	5.2
	530	100.0%	289	100.0%
7. Place of Injury:				
Hospital	362	67.8%	197	69.6%
Emergency room	69	12.9	16	5.6
Outpatient clinic	14	2.6	9	3.2
Nursing home	1	.2	3	1.1
Physician's office	84	15.8	56	19.8
Patient's home	4	.7	2	.7
	534	100.0%	283	100.0%
4. Foreign Medical Graduate?*				
Yes	90	17.4%	27	12.8%
No	426	82.6	185	87.2
	516	100.0%	212	100.0%
5. Board Certified?				
Yes			143	51.8%
No			133	48.2
			276	100.0%
6. Type of Settlement:				
Before trial	292	55.4%	178	62.2%
During trial	13	2.5	17	5.9
After trial but before verdict	1	.2	0	0
After judgment	24	4.5	15	5.2
Claim or suit abandoned	184	34.9	74	25.9
By review board	8	1.5	0	0
Before arbitration	1	.2	1	.4
During arbitration	2	.4	1	.4
After arbitration but before panel finding	2	.4	0	0
	527	100.0%	286	100.0%

**28.3% of Michigan doctors are foreign medical graduates.*

	As of March, 1977		March-November 1977	
7. Specialty:				
General surgery	113	21.4%	59	20.7%
Obstetrics-gynecology	98	18.6	62	21.8
General practice - minor surgery	62	11.7	14	4.9
General practice	49	9.3	35	12.3
Orthopedic surgery	44	8.3	22	7.7
Internal medicine	21	4.0	13	4.6
Anesthesiology	19	3.6	7	2.5
Otolaryngology	18	3.4	6	2.1
Urological surgery	13	2.5	4	1.4
Pediatrics	10	1.9	10	3.5
Neurological surgery	10	1.9	3	1.0
Psychiatry	10	1.9	6	2.1
Thoracic surgery	8	1.5	4	1.4
Ophthalmology	7	1.3	4	1.4
Emergency room medicine	7	1.3	0	0
Plastic surgery	6	1.1	3	1.0
All other	33	6.3	33	11.6
	528	100.0%	285	100.0%

	As of March, 1977		March-November 1977	
8. Physician's Age:				
35 and below	52	10.3%	32	12.2%
35-50	292	57.8	150	57.0
51-64	129	25.6	73	27.8
65 and above	32	6.3	8	3.0
	505	100.0%	263	100.0%

terpretation is needed to draw any conclusions and the findings must be considered only in conjunction with other information. No final conclusions can be drawn without a more complete data base, which will be provided by future surveys.

The MSMS Bureau of Economics wishes to thank the personnel of the Michigan Department of Licensing and Regulation for their assistance in compiling this information.

Technical Note:

Due to incomplete answers, the findings will not total the same for each specific data element. Also, the rounding of percentages accounts for the totals not consistently adding up to 100.

9. Specialty	Number of Claims	Percentage of Claims	Percentage of Specialty to Total Doctor Pop.	Total Payment by Specialty	Percentage of Total Payment
General surgery	59	20.7	8.9	$ 879,588	14.5
Obstetrics-gynecology	62	21.8	7.3	1,295,798	21.3
General practice - minor surgery	14	4.9	16.3†	721,250	11.9
General practice	35	12.3		1,613,000	26.6
Orthopedic surgery	22	7.7	2.9	122,750	2.0
Internal medicine	13	4.6	14.9	73,948	1.2
Anesthesiology	7	2.5	3.2	165,000	2.7
Otolaryngology	6	2.1	1.5	9,750	.2
Urological surgery	4	1.4	1.9	53,750	.9
Pediatrics	10	3.5	6.8	26,548	.4
Neurological surgery	3	1.0	.7	200,000	3.3
Psychiatry	6	2.1	7.4	60,000	1.0
Thoracic surgery	4	1.4	.6	32,000	.5
Ophthalmology	4	1.4	3.3	30,000	.5
Emergency room medicine	0	0	1.3	0	0
Plastic surgery	3	1.0	.7	2,250	< .1
All other	33	11.6	22.3	787,510	13.0
	285	100.0	100.0	$6,073,142	100.0

†Includes general practice with and without minor surgery.

10. County	***Number of Claims***	***Percent of Total Claims***	***Average Amount of Claims***	***Percent of Total MD Pop.***
Wayne, Oakland, and Macomb	172	61.9	$21,345	51.3
Other Counties in the Lower Peninsula	97	34.9	23,880	46.5
Upper Peninsula	9	3.2	7,222	2.2
	278	100.0	$52,447	100.0

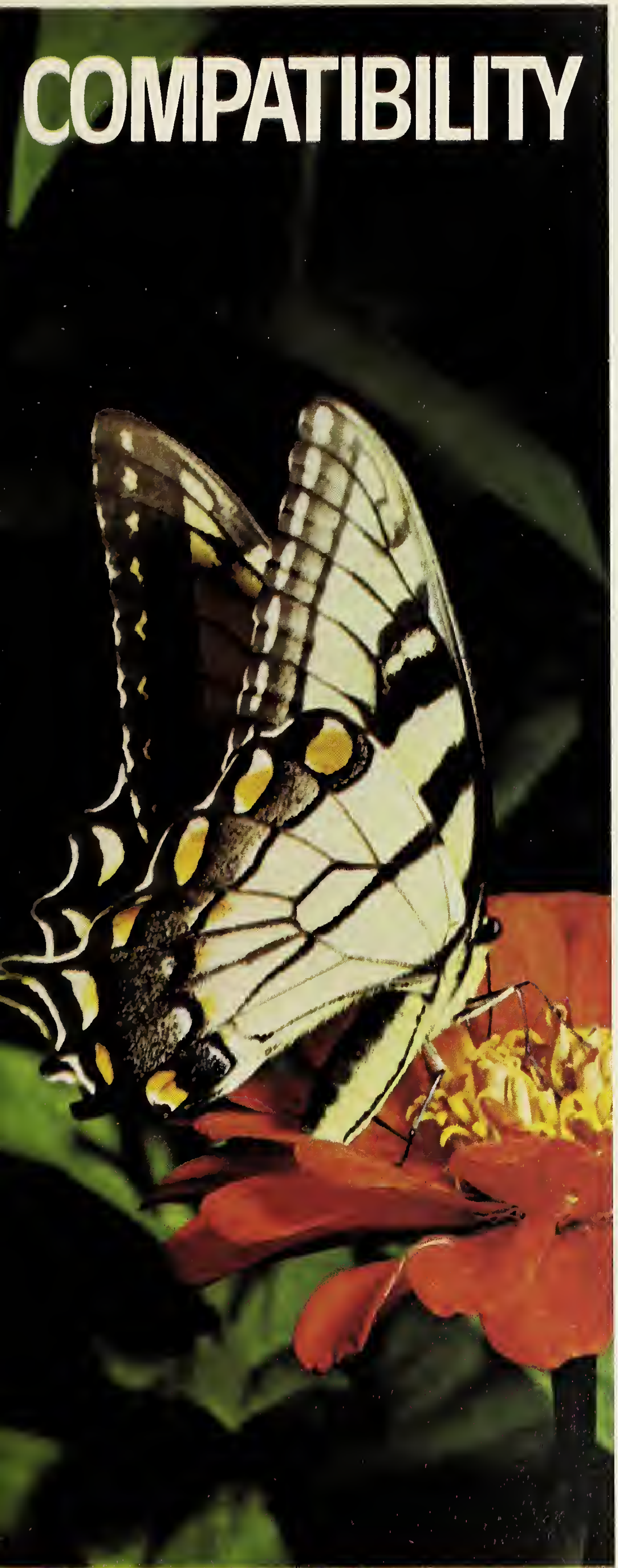
	As of March, 1977	**March-November 1977**
11. Plaintiff's Average Age:	34.9 years	34.1 years
Age 18 or under:	73	27

12. Number of Cases with No Indemnity Paid: 95/290 32.8%

Type of settlement	**Number of cases**		**Total indemnity paid**		**Average cost**		**Average payment to defense counsel**	
	3/77	*11/77*	*3/77*	*11/77*	*3/77*	*11/77*	*3/77*	*11/77*
1. Before Trial	261	178	$5,183,535	$3,185,094	$19,860	$ 17,894	$ 1,563	$1,898
2. During Trial	13	17	354,670	2,131,250	27,282	125,368	4,401	4,568
3. After Trial But Before Verdict	1	0	10,000	—	10,000	—	10,970	—
4. After Judgment	23	15	272,711	203,598	11,857	13,573	4,779	4,475
5. Claim or Suit Abandoned	165	74	1,515,534	551,200	9,185	7,449	1,113	1,343
6. By Review Board	8	0	68,000	—	8,500	—	7,889	—
7. Before Arbitration	1	1	0	2,500	0	2,500	0	0
8. During Arbitration	2	1	0	0	0	0	2,958	1,310
9. After Arbitration But Before Panel Finding	2	0	75,000	—	37,500	—	5,684	—
	476	286	$7,479,450	$6,073,642				

Total indemnity paid — all types of settlements

	As of March 1977		**March-November 1977**	
0 — $5,000	280	64.8%	54	39.1%
$5,001 — $25,000	97	22.4	44	31.9
$25,001 — $100,000	41	9.5	29	21.0
$100,001 — $250,000	8	1.8	7	5.1
over $250,000	6	1.4	4	2.9
	432	99.9%	138	100.0%



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan Injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®

(ISOXSUPRINE HCl)

20-mg tablets

MeadJohnson PHARMACEUTICAL DIVISION

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isn't worried about his

ext breath...

he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoonful (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

high theophylline for effective around-the-clock therapy

Quibron may give the asthmatic up to eight hours of bronchodilation with each dose and provides the high dosages of theophylline which are now believed necessary to keep patients free of acute attacks and chronic wheezing.

100% free theophylline

Quibron helps achieve high serum theophylline levels with minimal dosage volume...delivers 100% free theophylline in comparison to many other compounds which contain from 47% to 91% effective theophylline.

individualized theophylline dosage schedule

Today's more efficient usage of theophylline includes individualizing dosage and monitoring serum theophylline levels. The usual recommended dosages of Quibron are: Adults—1 to 2 capsules or tablespoonfuls every 6 to 8 hours; dosage may be cautiously adjusted upward when necessary to a maximum of 2000 mg theophylline per 24 hours. Children under 12—4 to 6 mg theophylline per kg/body weight every 6 to 8 hours; dosage may be cautiously adjusted up to 9 or 10 mg/kg every 6 hours.

Now, for the asthmatic who requires high-dose theophylline therapy for therapeutic serum concentrations

Mead Johnson Pharmaceutical Division announces

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

For Brief Summary, please see the last page of this advertisement.

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous)
and 180 mg glyceryl guaiacolate (guaifenesin)

The new high-dose theophylline capsule... for dependable theophylline therapy when products of lower dosage do not adequately control asthma symptoms.

Specially formulated

...for optimal efficacy

Quibron-300 is appropriate therapy for asthma patients whose symptoms are not adequately controlled on lower doses of theophylline, particularly for patients whose theophylline dosage has been adjusted upward to achieve therapeutic serum levels. In one study,[1] an average peak increase in FEV_1 of 35% was demonstrated after a single dose equivalent to one Quibron-300 capsule, and significant improvement in this pulmonary function lasted for nearly eight hours after administration.

...for optimal predictability

One Quibron-300 capsule q6-8h yields therapeutic serum levels (10-20 mcg/ml) in many adults. With a single dose, more than 75% of patients achieved serum levels potentially providing clinical benefit (5-15 mcg/ml). Half-life of theophylline varies widely from patient to patient, making monitoring of theophylline therapy important. Patient response may be monitored clinically if blood levels are not available as long as dosage does not exceed 1200 mg in 24 hours for adults.

...for optimal dosage convenience

The simple, convenient dosage of new Quibron-300—one capsule every six to eight hours—makes it easy for patients to comply with high-dose regimens often required to achieve therapeutic serum levels. Quibron-300 capsules may provide maximum therapeutic value with maximum convenience. In fact, the switch from a low-dose to a high-dose regimen may be accomplished by merely switching capsules, by stepping up to Quibron-300 capsules.

...for minimal theophylline side effects

Adverse reactions to theophylline are related to serum levels and are usually not a problem at concentrations below 20 mcg/ml. Of 45 patients studied[1] after a single dose, only seven reported adverse reactions. The most common reaction was a feeling of lightheadedness by three of these seven patients.

Reference 1. Data on file, Mead Johnson Pharmaceutical Division.

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Quibron—Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours. Children under 12: 4-6 mg theophylline/kg body weight every 6-8 hours.
Quibron-300— Adults: 1 capsule every 6-8 hours.
Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below $20\,\mu g$/ml.
How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

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Category I courses

Michigan Medicine ***each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.***

Because of space limitations, it is not possible to list the many continuing courses and series sponsored by many hospitals and organizations in Michigan. Information about those possible programs may be obtained from the accredited sponsors.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City State Hospital Traverse City
V.A. Hospital, Battle Creek
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: **May 15-19, Head and Neck Oncology. Location:** Towsley Center for Continuing Medical Education, University of Michigan, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Cost:** $500 for practicing physicians, $350 for physicians-in-training. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 42½ hours of Category I Credit.

Date: **May 16, Continuing Pathology Conference. Location:** The Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor, Michigan. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD.* **Approved for:** 6 hours of Category I Credit.

Date: **May 17, "Medical Ambiguities in Medical Decision-Making." Location:** Borgess Hospital Auditorium, 1521 Gull Road, Kalamazoo, 49001. **Sponsor:** Borgess Hospital. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** All specialties. **Cost:** $20. **Contact:** Robert Warnke, MD, 1634 Gull Road, 101 - Kalamazoo Medical Arts, Kalamazoo, 49001. **Approved for:** 7 hours of Category I Credit.

Date: **May 17, "Diabetes Mellitus — 1978." Location:** Hilton Inn, Lansing. **Sponsor:** Capital Chapter, Michigan Division of American Academy of Family Physicians. **Co-sponsor:** Michigan State Medical Society. **For:** Internal Medicine and Family Practice. **Cost:** $25. **Contact:** Richard L. Hatton, MD, 2321 Indian Hills Drive, Okemos, 48864. **Approved for:** 8 hours of Category I Credit.

Date: **May 18-19, Third Annual Course in Forensic Pathology. Location:** Radisson Cadillac Hotel, Detroit. **Sponsor:** Wayne State University School of Medicine and Wayne County Medical Examiner's Office. **For:** Pathologists. **Cost:** $80. **Contact:** Werner U. Spitz, MD, Chief Medical Examiner, 400 E. Lafayette Avenue, Detroit, 48226, 313/224-5648. **Approved for:** 12 hours of Category I Credit.

Date: **May 19-20, Nuclear Radiology Workshop. Location:** Towsley Center for CME, Ann Arbor. **Sponsor:** U-M Office of Postgraduate Medicine and Health Professions Education. **For:** All specialties. **Cost:** $140. **Contact:** U-M Office of Intramural Education.* **Approved for:** 16½ hours of Category I Credit.

Date: **May 19-20, Cancer Update — 1978. Location:** Marquette General Hospital. **Sponsor:** Marquette General Hospital, St. Frances Hospital, Escanaba and American Cancer Society. **For:** Areawide physicians and allied health professionals. **Cost:** None. **Contact:** Marie L. Connor, Marquette General Hospital, 420 W. Magnetic St., Marquette, 49855, 906/228-9440. **Approved for:** 8 hours of Category I Credit.

Date: **May 20, Care of the Injured Hand. Location:** Detroit Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** American Association for Hand Surgery; Michigan Academy of Plastic Surgeons. **For:** All specialties. **Cost:** $60. **Contact:** Kim K. Lie, MD, 27500 Hoover Road, Warren, 48093. **Approved for:** 7 hours of Category I Credit.

CATEGORY I/*continued*

Date: May 21-23, Symposium on Environmental Carcinogenesis. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** Michigan State University College of Human Medicine, College of Osteopathic Medicine, College of Veterinary Medicine, Basic Science Cancer Research Group and the Michigan State University Foundation in cooperation with Continuing Education Service. **For:** All specialties. **Cost:** $18, $6 for students. **Contact:** Kellogg Center for Continuing Education, MSU, East Lansing, 48824. **Approved for:** 15 hours of Category I Credit.

Date: May 22-26, Internal Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $260. **Contact:** Floyd C. Pennington PhD, U-M Office of Intramural Education.* **Approved for:** 34½ hours of Category I Credit.

Date: June 1-2, Current Topics in Blood Banking. Location: University of Michigan Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Postgraduate Medicine and Health Professions Education. **Cost:** $75. **Contact:** U-M Office of PGM/HPE.* **Approved for:** 12¾ hours of Category I Credit.

Date: June 1-2, Preventive Health Care for the Elderly. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 11 hours of Category I Credit.

Date: June 2, Annual Neuromuscular Symposium. Location: Kellogg Center for Continuing Education, Michigan State University, East Lansing. **Sponsor:** Muscular Dystrophy Association. **Co-sponsor:** Greater Detroit-Southeastern Michigan Chapter, Muscular Dystrophy Association. **For:** Neurologists, internists, pediatricians, family practitioners. **Cost:** $40. **Contact:** Michael A. Nigro, DO, Medical Director, Muscular Dystrophy Clinic, 400 W. Marshall, Ferndale, 48220, 313/399-8800. **Approved for:** 6 hours of Category I Credit.

Date: June 3, Cultural Differences: The implication for treatment of cultural and ethnic differences among families and between family and therapist. Location: Ramada Inn, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** 313/545-1144 or 313/662-2330. **Approved for:** 3 hours of Category I Credit.

Date: June 5-16, Biology of Aging. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology and U-M Medical School. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, MI 48109. **Approved for:** 30 hours of Category I Credit.

Date: June 7, "Depression and the Healing Process," A Live Televised Symposium. Location: Detroit (To be broadcast on TV channel)., **Sponsor:** College of Physicians and Surgeons, Columbia University. **Contact:** Health Projects International, Inc., 60 East 42nd St., Suite 726, New York, NY 10017. **Approved for:** 3 hours of Category I Credit.

Date: June 7-9, Evaluation and Education of the Chest Patient. Location: University of Michigan Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Postgraduate Medicine and Health Professions Education. **For:** Physical therapists, respiratory therapists. **Cost:** $120. **Contact:** U-M Office of PGM/HPE.* **Approved for:** 21 hours of Category I Credit.

Date: June 7, 14 and 21, Gastroenterology/Family Practice. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital. **Cost:** None. **Contact:** R. W. Pomeroy, MD, E. W. Sparrow Hospital.*** **Approved for:** 3 hours of Category I Credit.

Date: June 9-10, Current Topics in Neurosurgery — Diagnosis and Management. Location: Marquette General Hospital. **Sponsor:** Marquette General Hospital. **For:** Areawide physicians and allied health professionals. **Cost:** None. **Contact:** Marie L. Connor, Marquette General Hospital, 420 W. Magnetic St., Marquette, 49855, 906/228-9440. **Approved for:** 8 hours of Category I Credit.

Date: June 14, Symposium on Depression. Location: Kellogg Center for Continuing Education, Michigan State University. **Sponsor:** MSU College of Human Medicine, Ingham Medical Center Continuing Education Department, The Kellogg Center for Continuing Education. **For:** Psychiatrists, Family Practitioners, Pediatricians, Internists, and all others interested. **Cost:** MSU & IMC faculty: $14, others: $20. **Contact:** Symposium on Depression, Continuing Education Service, The Kellogg Center for Continuing Education, Michigan State University, (517) 353-7822. **Approved for:** 6 hours of Category I Credit.

Date: June 16-18, "Exploring the Effects of Mid-career Stresses Upon the Medical Family." Location: Meadowbrook Hall, Oakland University. **Sponsor:** Michigan Psychiatric Society. **Co-sponsor:** Michigan State Medical Society. **For:** Physicians and spouses. **Cost:** $12 per credit hour. **Contact:** Committee on Well-being of Physicians, Michigan Psychiatric Society, Box 950, East Lansing, 48823. **Approved for:** 18 hours of Category I Credit.

Date: June 22-24, Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $25. **Contact:** Wayne State University, Division of CME,** or Benjamin E. Henig, MD, 308 Michigan Ave., Grayling, 49738. **Approved for:** 12 hours of Category I Credit.

Date: June 23-25, Urology Outing. Location: St. Clair Inn, 500 N. Riverside, St. Clair, 48079. **Sponsor:** Wayne State University School of Medicine, Div. Continuing Medical Education. **Cost:** $125. **Contact:** Wayne State University School of Medicine, Div. of CME.** **Approved for:** 12 hours of Category I Credit.

Date: June 25-30, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $200. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21½ hours of Category I Credit.

Date: June 28, Psychiatric Problems as Encountered in Family Practice. Location: Edward W. Sparrow Hospital, Lansing. **Sponsor:** Department of Family Practice, E. W. Sparrow Hospital. **Co-sponsor:** Michigan Academy of Family Physicians. **Cost:** None. **Contact:** Jean Machtel, CME Secretary, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., P.O. Box 30480, Lansing, 48909. **Approved for:** 4 hours of Category I Credit.

Date: June 29-30, Mental Health in Aging. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology and U-M Medical School. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, University of Michigan, 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

Date: July 11-13, Annual Educational and Social Meeting. Location: Boyne Mountain Lodge. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **Cost:** None. **Contact:** Robert S. Holm, MD, Michigan Chapter Chairman, American Academy of Pediatrics, 515 Lakeside Drive, S.E., Grand Rapids, 49506. **Approved for:** 7 hours of Category I Credit.

Date: July 21-22, Mental Health Audit Seminar. Location: Hilton Inn, 7501 W. Saginaw Highway, Lansing. **Sponsor:** Interqual, Chicago. **For:** All mental health professionals. **Cost:** $150. **Contact:** Monica Eckart, Seminar Registrar, 312/751-2327, or 800/621-6109. **Approved for:** 12 hours of Category I Credit.

Date: July 27-28, 1978 Coller-Penberthy-Thirlby Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center, Traverse City. **For:** All specialties. **Cost:** $25. **Contact:** Thomas Auer, MD, % Munson Medical Center, Traverse City, MI 49684. **Approved for:** 9 hours of Category I Credit.

Date: July 29-August 2, 32nd Annual Convention and Scientific Assembly, Michigan Academy of Family Physicians. Location: Sugar Loaf Village, Cedar. **Sponsor:** MAFP. **Cost:** $65 members, $75 non-members. **Contact:** Rita Feldkamp, (313) 455-4200. **Approved for:** 30 hours of Category I Credit.

Date: July 31-August 4, and November 6-10, Principles of Milieu Practice: Working with the Elderly in Treatment Settings. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 35 hours of Category I Credit.

Date: Sept. 13, Third Annual Renal Disease Conference. Location: Kalamazoo Center, 100 West Michigan, Kalamazoo, Michigan 49006. **Sponsor:** Michigan Nephrology Center. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians, Internists, General Practice, Nephrologists. **Cost:** $35. **Contact:** Jeffrey Block, M.D., Michigan Nephrology Center, 1521 Gull Road, Kalamazoo, Michigan 49001. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 7-9, MSMS Annual Scientific Meeting. Location: Detroit Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** MSMS. **For:** All specialties. **Cost:** $3 per hour for members, $15 per hour for non-members. **Contact:** Herbert Auer, MSMS headquarters, 517/337-1351. **Approved for:** 20 hours of Category I Credit.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't of PGM/HPE, Ann Arbor, 48109, (313) 764-2287.

**WSU Division of CME, Room 1206, Scott Hall, 540 E. Canfield, Detroit, 48201 (313)577-1180.

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

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Michigan's mental health system builds on developments of past decades

(The following is the first in a three-part series on Michigan's public mental health care system. Subsequent articles will deal with current public policy issues confronting the Michigan Department of Mental Health and physicians providing mental health care, and with a view of future mental health issues. This first article provides the perspective of recent decades' developments.)

From the Michigan Department of Mental Health

"The old order changeth," said Alfred, Lord Tennyson, "yielding place to new."

In few areas of medical care has the old order changed as rapidly as in the field of mental illness and mental retardation. Physicians outside these specialty areas — including those earning medical degrees in the late 60's and early 70's — frequently express surprise at the magnitude and speed of the changes.

"I had no idea," a young family practitioner confided to me after a recent talk, "that 50 percent of admissions to psychiatric hospitals are discharged in less than 30 days. I would have guessed they stayed two, maybe three years." Such misconceptions are not uncommon.

Revolutionary changes

The purpose of this paper is to summarize events influencing the old and new order, and examine ways in which technological developments and changes in professional and societal attitudes are altering the manner in which we provide care for the mentally ill and mentally retarded.

The revolutionary nature of the changes, which mark each of the decades in the mid-20th century, is indicated by a glance at key developments.

Whereas the 1940's were characterized by massive overcrowding, long waiting lists, and unavailability of staff due to the war effort, the 50's were the era of discovery and renewal — psychotropic drugs were introduced; long-deferred building programs initiated. But the number of resident patients in Michigan's public mental health system continued to climb.

The 60's witnessed another new hope; a dynamic young president extolled the virtues of community mental health services and called for creation of more than 2,000 centers across the nation to meet the mental health needs of Americans.

The principle issue of the 70's is quite unlike earlier problems, namely, the nationwide effort to secure the civil rights of the mentally ill and disabled. It is rapidly leading to what is certain to be the central issue of the 80's, namely the battle to guarantee quality of care in our public mental health system.

In brief, the mental health scenario of the recent past and present, far from being the stagnant story alleged by a few self-appointed spokesman, is more akin to the adventures of Horatio Alger or travels of that famous surgeon, Gulliver, who befriended the Lilliputians and came to understand the Houyhnhnms.

The Forties: So Little For So Many

As recently as the 1940's, psychiatric treatment as we know it today was in its infancy, medications limited and rehabilitation as much a matter of spontaneous remission as any other demonstrable factor. The assumption underlying all cases was that treatment would require a very long time — perhaps a lifetime. With few exceptions, services were available only in large, overcrowded state hospitals, far removed from the major population centers which they served.

As the decade opened, the state system for the mentally ill included five hospitals at Kalamazoo, Pontiac, Traverse City, Newberry and Ypsilanti. The first four were opened in the 1800's; only Ypsilanti was of more recent vintage, having been opened in the early 1930's and expanded by 1,000 beds at the end of the decade. A special hospital for the criminally insane, opened in the late 1800's was operated at Ionia.

In total, these six hospitals provided care for more than 12,000 persons at an average cost of 85 cents per day.

For medication, physicians relied on sedatives such as chloral hydrate and the barbituates. Hot packs, cold packs and continuous baths were also used to relax patients and/or provide a subtle stimulus environment. For selected patients, convulsive therapy (induced by insulin, indoklon or electricity) was prescribed. The treatment was administered without the benefit of effective muscle relaxants. Occupational and recreational therapy were widely beheld as advances which would alleviate the magnitude of the problem.

The mentally retarded — including a substantial number of persons with IQ's in the 60's and 70's — were placed in equally overcrowded state home and training schools at Lapeer, Coldwater and Mount Pleasant, with the expectation that they would live out their lives in these settings. The rationale, reflecting the popular belief of that day, was that they would be better off "with their own kind." A special home, in Caro, served epileptics — many of whom also were retarded.

The four homes, in total, served nearly 5,500 persons; the huge complex in Lapeer, oldest of the facilities, provided care for 3,800 children and adults.

The human resources so critical for active treatment, rehabilitation and habilitation programs were absorbed by the war effort. Physicians, nurses, social workers — even nursing and domestic services personnel — were in short supply. Annual employee turnover in some facilities exceeded 100 percent per year. Given a beginning salary of $40 a month plus room and board, the turnover rates did not surprise many. The work week was 54 hours in Michigan hospitals and more fortunate employees had a room in an attic or above a bakery or other utility building; newcomers had a room on the wards.

Added to this list of problems were the disturbing reports from the armed forces and the selective service system about the state of the nation's mental health. Slowly, the recognition was growing that mental illness and related emotional disorders were not isolated problems but rather a significant public health issue.

But there were bright spots on the horizon. The concept of prevention was gaining support. In the late 1930's, child guidance clinics had been established in Detroit, Traverse City, and Lansing through a private foundation, the Children's Fund of Michigan. Using these clinics as models, the State of Michigan in the 1940's established additional child guidance clinics in Muskegon, Saginaw, Kalamazoo, Marquette, Ypsilanti, Detroit, Pontiac, Grand Rapids and Flint.

As the war entered its final year, the Michigan Legislature created a Department of Mental Health with a far broader charge than its predecessor, the State Hospital Commission.

In 1946, the Congress passed the National Mental Health Act, providing a method for financing research and training programs, and assisting states in establishing community mental health services.

But as the decade ended, the population in Michigan's state hospitals totaled more than 20,000; the hospitals were overcrowded, even by the minimal standards of the day, by more than 20 percent. Approximately 1,000 were on waiting lists, another 1,000 were estimated to be in need of service but applications for admission or commitment had not been made because the known waiting list was so long.

The Fifties: Discovery and Development

The accidental discoveries of the first prototype antipsychotic compounds, and their rapid introduction and acceptance during the fifties, are clearly the most important developments of the decade. More accurately, it could be said they constitute the most significant breakthroughs in the entire history of man's attempts to treat mental illness.

Each of the three classes of drugs commonly considered to constitute the major tranquilizers traces its origin to the 50's.

Today, the phenothiazines as a class, and especially chlorpromazine, the prototype, are among the most widely used drugs in the field of medicine.

Phenothiazine itself was first synthesized in 1883 but it was not until 1950, in France, that chlorpromazine was synthesized. Recognition of the unique effects of chlorpromazine and its use in psychiatric patients in 1952 mark the beginnings of modern psychopharmacology.

The term tranquilizer was introduced in 1953 to characterize the effect of reserpine, the principle alkaloid of Rauwolfia serpentina. Today, reserpine is mainly of historical interest in psychiatry. It is less effective as an antipsychotic than other available drugs and is rarely used for this purpose.

By the end of the decade, the butyrophenones, the third class of major tranquilizers, were introduced. The prototype, haloperidol, although not used in this country until the 60's, has proven to be an effective alternative to the more familiar phenothiazine drugs.

Librium and Valium are perhaps the best known of the benzodiazepine compounds although they were not introduced until the 60's.

Progress also was achieved during the late 50's during therapeutic trials of drugs to counter depression. Currently, the compounds most widely used for the treatment of depression are selected from the class referred to as the trycyclic antidepressants. The pharmacological properties of imipramine, the best known of this class, were first investigated in 1948 although clinical trials were not initiated for another ten years.

Among the monoamine oxidase (MAO) inhibitors, iproniazid was the first to be introduced into psychiatry for the treatment of depressed patients (1957). Its initial successes led to the development and clinical trials of many additional compounds that also had the capacity to inhibit MAO.

Introduction and full-scale acceptance of the psychotropic medications set in motion a series of events that could not be imagined as the 50's began.

These compounds would change inexorably the pattern of care and treatment which had taken place in this country for 100 years and more. But unlike the miracle antibiotic drugs of the preceding decade, the psychoactive drugs are not considered curative. Many patients display some residual symptomatology and clearly, drugs cannot provide the insight to a patient that can be achieved through psychotherapy.

Drug treatment in psychiatry is still primarily empirical and it should be noted that a psychiatric diagnosis in and of itself does not determine the nature of chemotherapy.

However, the psychoactive medications can alter a patient's emotional and mental state and permit participation in other therapies. Thus, the agitated patient can be calmed, a highly anxious patient can be soothed and a depressed, withdrawn patient may be stimulated sufficiently to communicate with a therapist.

In brief, psychoactive drugs for the first time in the history of man provided a choice of treatment modalities.

Although the pharmacological breakthroughs of the 50's overshadowed all other advances in the field, progress was achieved on other fronts.

On the national level, the Congress created in 1955 the Joint Commission on Mental Illness and Health and directed it to analyze and evaluate the needs and resources of the mentally ill in the United States and to make recommendations for a national mental health program.

In Michigan, recognizing the critical need for improved and additional hospital beds for the mentally ill and mentally retarded, the citizens of the state approved in the early 50's an unprecedented $60 million bonding program to finance a construction program.

To meet the needs of the burgeoning population of the metropolitan Detroit area, the Northville State Hospital with a capacity of nearly 2,500 was opened in early 1952.

Among other projects completed with funds from the bonding program was the Hawthorn Center, the Department's first residential treatment facility designed exclusively for children. The first patients were admitted in August, 1956.

During the same period, the Department opened its major research and training center, the Lafayette Clinic in Detroit. Operating in conjunction with several academic departments of Wayne State University, the Center achieved during its first decade an international reputation for its scientific studies of schizophrenia.

To meet the critical demand for space to care for the mentally retarded, the state leased space in the Detroit area from the Michigan Children's Hospital and in the Battle Creek area from the U.S. Department of the Army.

The effort to develop community-based outpatient programs also continued in the 1950's with new child guidance clinics added in Port Huron, Petoskey, Battle Creek, Benton Harbor, Mount Clemens, Jackson, Mount Pleasant and Royal Oak. An adult clinic established on a pilot basis in Detroit during the late 1940's was continued and new adult clinics developed in Muskegon, Lansing, Saginaw and Grand Rapids.

Despite the significance of the psychopharmacological breakthroughs and the efforts to expand outpatient services, the total number of persons in state hospitals and homes for the mentally retarded continued to grow. At the close of the decade, more than 19,000 persons were in state hospitals, an increase of about 20 percent from 1950. An additional 750 children and adults were awaiting admission.

At the state home and training schools, more than 12,000 were in residence — an increase of more than 50 percent during the preceeding 10 years. On the doorsteps stood another 1,200 — waiting for a vacancy so they could enter.

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ISSUE 78-2

A monthly digest of observations and recommendations arising from the editors' ongoing full-time work as advisors to medical practices on such matters as business systems, personnel management, office facilities, group practice problems, professional corporations, retirement planning and personal finances. The "Action Note" at the end of each item provides the reader with a reminder for prompt action and handy future reference.

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Group Practice

1 THE CONTINUING TREND IN DIVIDING INCOME — PRODUCTIVITY

While members of many small groups (two to six doctors) continue to resist it, there is a continuing trend in how they divide their practice net income. More and more of them are recognizing that the individual physicians' respective production of fees must be recognized.

It has been said that "Good ideas flow from the West to the East," and this has some truth in medical practice management. Productivity division of income certainly seems more prevalent away from the East Coast, but even our eastern states are joining the pattern.

In so many group situations, the choice of production as at least a partial factor in deciding members' incomes is almost inevitable. All doctors practicing together simply are not the same. Some will work faster or be more popular with patients; some will be much more ambitious or perhaps even restless; some will legitimately require more income and be willing to work harder to earn it. Such factors cannot be ignored indefinitely.

On the other hand, some doctors will want to phase down their work levels, perhaps in progress towards retirement; others simply will not want or be able to maintain hectic practice demands. Having an objective measuring device for giving such doctors less practice income will often be a welcome relief. The "self-adjusting" of a doctor's income share to his production is particularly valuable on this "down side" since changes in his activity level will not require continued renegotiation of his pay.

Many groups validly object that there are compelling reasons for continuing to divide their incomes in equal shares. These "group factors" are indeed often important, from which an effective compromise can be reached. Perhaps half the net income can be divided equally, while the other half can be divided according to individual production. Such a result recognizes the value of both approaches, retaining an equality factor while also conceding to the inevitability of productivity variations.

ACTION NOTE — **Recognize that the conversion towards dividing group income partly or wholly on the basis of each doctor's production is a continuing, perhaps inevitable, trend. Consider whether it should be applied to your partnership or corporation.**

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Telephone

2 SPECIFIC BACK-UP RESPONSIBILITY FOR HANDLING THE TELEPHONE

In our view, complaints about a medical office's handling of phone calls should not casually be disregarded. Continuing busy signals, failing to answer calls promptly within just a few rings and leaving callers too long on "hold" are three common problems to be avoided.

Many offices understandably object that the receptionist(s) simply cannot cope with all of the telephone's demands. We recognize this likelihood, and we also concede that hourly variations in telephone activity may make it wasteful to hire extra help just to handle peak busy times. And yet these peaks may require help--for example, when a receptionist has two patients checking out, a caller on hold, another caller on the line and then the third line rings!

Each office should thus have back-up telephone responsibilities specifically assigned to other assistants. These **"secondary responsibilities "** should be written into the employees' individual job descriptions so there is no uncertainty over the assignments. Thus, when the receptionist (assumed to be primarily responsible for the telephone in most smaller offices) is visibly unable to take a call or when a line rings perhaps three times, the person assigned as "Number 2 on the phone" must answer it promptly. If she is also tied up, then the person assigned as "Number 3" must answer.

Such a format works effectively because it removes the element of doubt. Each employee will know when she must respond; the old "Alphonse and Gaston" routine of waiting for the other person to act would be avoided. The primarily responsible person (typically the receptionist) must, of course, be able to juggle several calls and patients, but the back-ups help assure responsiveness when she becomes overwhelmed. The result may be better patient service and less employee tension.

Action Note — While keeping one person primarily responsible to handle your telephone calls, be sure other assistants have clearly defined "back-up" responsibilities for the overwhelming peak demands.

Third Party Insurance

3 SPECIFIC JOB ASSIGNMENTS FOR INSURANCE FORM PREPARATION

Preparing Blue Shield, Medicare, public welfare and commercial insurance claim forms is among the least satisfying employee tasks. And yet their prompt handling is essential to a practice's cash flow, whether the office or the patient will receive the insurance proceeds. Some offices are avoiding individual preparation of claim forms through computer billing or "superbill" routines, but most practices still rely on manual preparation of each individual form.

Where the office prepares the insurance claim forms, real emphasis must be given to personnel assignments. Third party form preparation is a good example of specializations's advantages, for one assistant (or several) can learn exactly what each insurer requires and, conversely, what will hold up processing. She will become able to prepare the forms faster and more accurately by reason of her routine. She will also likely develop a rapport with each insurer's claims processors, thus becoming able to expedite problem claims.

Furthermore, assigning the form preparation to a specific employee permits the doctors and/or manager to hold her responsible for the work. If there becomes a back-log of unprepared forms, the person accountable for the delay can be identified. Offices telling us that "everyone pitches in and does the insurance forms" are likely to be the ones furthest behind. Our old adage should be remembered: "If everyone is responsible, no one is responsible."

Some practices spread the insurance task among several assistants in a perfectly acceptable way. One person may, for example, be responsible to prepare all Blue Shield and Medicare forms; another secretary handles all commercial claims; and still another person might handle all public welfare forms. This allocation spreads the work but still takes advantage of our insistence on specialization and accountability.

ACTION NOTE — Be sure the preparation of third party insurance claim forms is specifically assigned to an employee or employees; avoid spreading the task casually among all staff.

Equipment

4 SHOULD YOU OR YOUR CORPORATION BUY YOUR PRACTICE EQUIPMENT?

Accountants and attorneys, including ourselves, sometimes recommend that a physician or group buy his or their practice equipment personally and then rent it to the professional corporation involved. There are supposed to be several appealing tax and practical advantages, but we consider them far less significant when given critical evaluation.

The first supposed advantage is that the investment tax credit can be taken to reduce the purchasing physician's own tax liability. While the point rarely arises, perhaps due to lack of knowledge, a specific provision of the tax law prohibits the credit in such situations. This provision, Section 46(e)(3) of the tax Code, denies investment credits to an individual leasing manufactured property unless certain requirements are satisfied. Those requirements are unlikely to be included in the corporate rental arrangement.

A second tax argument for personal ownership and rental is that accelerated depreciation can be taken by the physicians, thus creating a loss on their personal tax returns in the first few years of ownership. This tax saving has merit, although the same saving would have been available to the corporation as owner. Had the corporation taken the accelerated depreciation directly, its available income would have been reduced and its doctors' salaries would in turn have been reduced. The net tax effect to the doctors would thus be substantially the same.

Finally, advisors sometimes recommend that ownership of the equipment be passed over to others for tax saving reasons. A trust for the doctor's children might, for example, be created and then be the owner/lessor of the equipment. While such tax and estate planning might be proper in a few cases, we have seen it go awry. Particularly if the doctor involved later takes on an additional partner or partners in the practice using that equipment, its ownership fixed in his tax-saving trust can become a real obstacle to a good group relationship.

ACTION NOTE — Be particularly critical whether you should personally buy and lease equipment to your corporation; recognize that many of the arguments in favor may be more illusory than real.

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Hiring A Physician

5 SHOULD A YOUNG DOCTOR BE PAID MORE IF HIS SENIOR BECOMES DISABLED?

A contract engaging a new doctor for his first year of practice typically limits his continued salary in case of illness. The most common provision is that his pay will continue for only one month of disability. Some of the young doctors are, however, validly raising the opposite concern--should an employee-physician continue receiving the same salary if his senior doctor remains disabled for an extended period of time?

Particularly if a new doctor joins a previously solo practice, we agree with this concern. Before the hiring, the senior doctor would have had no practice income at all upon disability once his accounts receivable had been exhausted. The hiring thus provides him with a safety factor for continued income, but it should be kept in perspective.

While a young doctor will have contracted to devote his full time and effort to the practice, the work demands when one half of a two-man practice is out sick can become intolerable. They may be far beyond what had been anticipated. For a period of time, upwards of three months, that situation should be accepted, but after some point in time the situation may become totally unfair.

For these reasons, we often recommend a special provision in contracts hiring new physician-employees. It states that if the senior doctor (particularly if a solo) should be absent due to illness or injury for more than a specified length of time, then the young employee's salary will be increased. The increase might be to a higher fixed salary or it might be geared to his production of income, but the important point is to recognize the principle of fairness involved.

ACTION NOTE — **In negotiating to hire a new physician-employee, consider what increased pay would be fair if the senior doctor should become disabled for more than a moderate amount of time.**

Charts and Records

6 SHOULD CHARTS BE FILED ALPHABETICALLY OR NUMERICALLY?

While hospitals and large medical clinics understandably require numerical filing of all patient charts, we feel quite strongly that small and medium sized practices should stick to alphabetical identification.

Virtually all medical practice management consultants agree on this preference for "alpha" filing. It provides the surest and easiest retrieval of a chart since an assistant need merely go directly to the patient's name. Numerical systems, on the other hand, require the maintenance of a separate set of reference cards so each patient's name can be translated to his or her number before the chart can be pulled. The extra step is burdensome to assistants in "numero" offices, and the opportunity for clerical error is greatly magnified.

Maintaining the cross reference file from name to number has proven to be extremely disconcerting to medical offices. We remember one practice in which several weeks' index cards were awaiting preparation; and in another office some of those cards had been misfiled or lost, causing the charts themselves to be unreachable. While these problems can be avoided by typing each patient's file number on his or her ledger card, the extra steps and the opportunities for error would remain.

Offices encountering the variety of complaints over numerical filing should seriously consider converting to "alpha". File conversion is obviously annoying and time-consuming, but it is a one-time clerical job which can thereafter constantly avoid the old inefficiencies. Especially if conversion to color coding would be appropriate anyway (which we often urge*), the simultaneous abandonment of numerical filing should be helpful to a small or medium sized office.

*See "Don't Delay Color Coding Your Medical Record Folders" (#77-5).

ACTION NOTE — **Recall our strong bias against numerical filing of medical charts; consider switching to "alpha" along with color coding of the file folders.**

Professional Corporations

7 WILL YOUR GROUP TERM LIFE INSURANCE WITHSTAND IRS AUDIT?

Employer group term life insurance is an excellent fringe benefit. Up to $50,000 face value per doctor, the corporations's premium payments are fully tax deductible and yet not taxed as income to the insured physician; as to coverage over $50,000, only a moderate portion of the premiums are taxable to the doctor. Much lower coverage of $5,000 or $10,000 need be obtained on each assistant, usually at very low cost. We thus consider employer group term coverage by far the best way for most incorporated physicians to satisfy some of their life insurance needs.

Many corporations unfortunately obtain coverage which technically fails to qualify for the desired tax treatment. While we are not aware of IRS audits catching the deficiencies, we believe our readers should be aware of the pitfalls. The best approach is to structure the coverage so the possible, and really valid, tax attacks will be prevented.

First of all, the insurance obtained should be under one master contract between the insurance company and the professional corporation. It should call for coverage of each "full-time"* employee at specified dollar levels, varying by salary, employee classification or the like. Despite this concept, however, we see many small groups who assume that their purchase of individual term insurance policies for each employee (sometimes even through different insurers) will qualify. It does not, nor do individual term policies issued through medical society group programs.

Secondly, the tax law provides that in corporations of less than ten insured employees there may be no medical examination for issuance of the insurance. Since many insurers will not issue $50,000 or $100,000 of coverage to a doctor when only a few employees are involved, this problem can be almost (but not quite) insurmountable in obtaining truly valid tax-favored coverage.

In addition, group plans for fewer than ten employees must meet a special rule as to the employee coverage classifications. The classes must be uniformly determined (physicians in one coverage, managers and supervisors in a second class and others in a still lesser coverage, for example), and no class can provide more than 2 1/2 times the insurance coverage of the next lower class. Furthermore, the coverage for the top class cannot have more than ten times the insurance of a member in the lowest class. Therefore a not unusual program calling for $100,000 coverage for each physician-employee and $5,000 insurance for each clerk would not qualify.

*The Regulations call for all employees working 20 hours or more per week to be considered "full-time", although many of the insurance contracts instead call for coverage only at 30 hours per week--a problem in itself.

ACTION NOTE — **Employer group term insurance is such an excellent fringe benefit that the special tax rules for small (under ten lives) professional corporations should be carefully observed. They are too often ignored.**

Income Taxes

8 IS THERE ANY HOPE FOR THE HOME OFFICE DEDUCTION?

The Tax Reform Act of 1976 specifically struck down the so-called "home office deduction" which had become so popular with physicians. While the deduction is still available (though limited) to the extent patients are actually seen at home, the Act very clearly intended to kill its usual applications.

Despite this tax law, some advisors are still suggesting arguments for claiming the home office deduction. And some physician-clients, eager to grasp any straws, are still claiming portions of their home expenses as business deductions. We believe these claims are generally unwise, for the dollars involved are not usually significant enough to warrant the increased likelihood of IRS audit--and the nearly certain tax assessment upon such an audit.

Some advisors, including us, have considered an approach for incorporated physicians. The Act disallows the business deduction of home expenses, but it does not expressly prohibit the **rental** of a person's home office. Therefore, perhaps a doctor's corporation could pay him rent for his business use of a portion of his home, that rent essentially equalling the expenses he would otherwise have deducted. When income and expenses so cancel out, many accountants then ignore reporting the items for tax purposes at all.

We do not usually believe this corporate approach is advisable. First of all, the Act's prohibition probably extends to the rental situation anyway. Secondly, if the arrangement is then rejected upon IRS audit, the tax result will be worse than if it had not been tried at all. The rental payment would be treated as a "preferential dividend", subject to double tax at both the corporate and the doctor's levels,* while the home office/rental expenses would be disallowed

In our view, there are enough valid approaches towards reducing tax obligations, especially when a professional corporation is involved, that the home office deduction should be abandoned as a lost cause. Neither the eagerness of an advisor (or writer) to look smarter than others nor the physician's emotions of losing a tax deduction should cause this loss of perspective.

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*See "The IRS' 'Preferential Dividend' Approach Dictates Caution in Handling Business Expenses" (#77-1).

ACTION NOTE — If you are still claiming a portion of your home expenses as business deductions, either directly or through your corporation's rental arrangement, reconsider whether to continue it in view of the Tax Reform Act.

Personnel

9 URGE YOUR KEY ASSISTANTS TO JOIN THE AAMA

While physicians tend, usually for important reasons, to belong to a great many professional organizations, their office assistants are unlikely to have any significant work-related memberships. We consider this unfortunate, for exposure to other people involved in similar business activities is valuable to professional development.

There is one well-organized and widely recognized organization for medical office employees. It is the American Association of Medical Assistants ("AAMA"), headquartered in Chicago* and having many state and local chapters. We recommend to countless clients that they encourage their office managers' and senior assistants' active membership and involvement. That encouragement usually includes office payment of their dues and association expenses and time off for their attendance at association meetings and courses.

The several advantages of promoting AAMA activity should be obvious. First, the policy provides a recognition of the staff's professional character and the doctors' esteem for it. As to personnel motivation, a high level of respect for the employees and their jobs is extremely important.

Secondly, the Association's meetings and workshops create a means for key employees to discuss their work with their peers. Such intercommunication will almost surely provide ideas for performing one's own job and/or managing one's office. Ideas are the essential ingredients for constant improvement, and hence they are destined to result in greater office effectiveness and efficiency.

The AAMA maintains a certification program by which an assistant can earn the "CMA" designation. This is a goal to be encouraged, for it motivates employees to achieve while providing a psychic status to those who achieve it. A few doctors have objected that an assistant earning her "CMA" would then insist on higher pay or else consider herself better able to leave for another job--reasoning which we consider extremely shallow.

Although state and local AAMA chapters vary in size, quality and activity, we believe the encouragement should be provided. Even in poor chapter areas, newly joining assistants can take the pride in helping build a worthwhile organization with employer backing.

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*The national office's address is: One East Wacker Drive, Chicago, Illinois 60601.

ACTION NOTE — Encourage your office manager and key assistants to join and become active in the AAMA; have them obtain membership information from your local or state medical association.

Collections

10 GIVE YOUR RECEPTIONIST A VISUAL AID TO HELP HER COLLECT FOR OFFICE VISITS

Obtaining payment for services as the patients leave the office ("over-the-counter") has been repeatedly emphasized as a key to successful collections. An office effectively using such a policy can increase its receipts, decrease its billing costs and remove collections from becoming an interference to good patient relations.

How well the policy is applied depends, however, upon the personality, diligence and training of one individual--the receptionist. She must courteously and professionally make each patient aware of his or her obligation to pay at that time, and she must be able to handle a variety of objections without embarrassing the patient, herself or the office.

Some receptionists, otherwise excellent at their jobs, complain at being uncomfortable in the collection task. Therefore, to the extent such people can be given tools to reinforce their presentations to patients, the effort should be well worth any small cost. That is why we often recommend some form of a "visual aid" to help an employee with the task.

One excellent visual aid can merely be a small, perhaps 4" x 7", cardboard card bearing a printed legend such as:

> "The policy of this office is to require all patients to pay for their visits before leaving. Your cooperation will be appreciated."

This card could be kept handy at the receptionist's desk. She could pull it out and show it to any questioning patient, thus providing her a sort of emotional "crutch" as she describes the payment system. If it can help a good employee perform this important task more successfully by providing some psychological support, it will be a fine small investment.

ACTION NOTE — To help your receptionist overcome any timidity or awkwardness in asking patients for payment, give her a small printed card to use as a "visual aid".

What to expect and do if you are sued

This information is advisory only and is *not* intended to imply or establish a standard of care, or to substitute for advice of personal legal counsel.

The explosion in the number of malpractice claims has increased every physician's chances of becoming the target of a lawsuit. If you are sued, here's what to expect.

You will be notified of the suit in one of two ways. A process server will present you with a copy of the complaint filed in local court, or you will receive a notice in the mail that a lawyer has placed an "attorney's lien" against money your patient may receive. The attorney's notice simply means that the patient has consulted him about a possible claim against you and the attorney now retains an interest in any settlement or damage award.

When you receive the complaint, your first reaction probably will be highly emotional. The complaint will be a scathing attack on your abilities as a physician. Keep in mind that the wording of the complaint is only a legal statement that establishes grounds for the suit. And remember, a calm, level-headed approach and adequate preparation are the keys to your defense.

As soon as you learn you are being sued, notify your insurance company by certified mail, and request a receipt. Keep a copy of all correspondence with the insurance company and be sure you retain the original copy of the complaint.

Your insurance carrier will provide you with an attorney, but you may elect to hire your own legal counsel. Rely on the attorneys for advice. Be candid and furnish all the necessary facts and records. Dates of treatment, descriptions of therapy, progress notes and prescription records are all important in preparing your defense. In fact, it would be helpful to summarize the treatment in diary form. *Never destroy or alter existing records in an attempt to strengthen your case.*

Avoid direct communication with the patient or his attorney. Do not correspond with them, and decline invitations to discuss the suit with anyone — especially the local media. If the patient or his attorney attempts to negotiate a settlement, notify your insurance company immediately.

Now the stage is set for the discovery proceedings. Although this will be handled by your attorney, here's a step-by-step account of what will happen:

(1) *You must file a written answer to the plaintiff's charges.* Along with the original complaint notifying you of the suit, you will have received a summons ordering you to appear in court and present your answer.

(2) *The plaintiff may file a reply to your written answer.* This depends on your allegations. In his reply, the plaintiff will deny some or all of the facts which you presented. Frequently, he will add new facts to counter your statements.

(This is the sixth in a series of articles on risk management to appear in Michigan Medicine. *It is sponsored by the MSMS Committee on Professional Liability, chaired by Robert M. Leitch, MD, Battle Creek, MSMS immediate past president. The material was originated with the Illinois State Medical Society, which has prepared tape cassettes on the subject.)*

(3) *You may be required to provide written answers to the plaintiff's questions.* This question and answer process is called interrogatories — part of the formal discovery process before a trial takes place. Your answers are made under oath.

(4) *Your attorney may send interrogatories to the plaintiff.* The plaintiff's answers will help determine the exact nature of the claim and prepare your defense.

(5) *Both sides will probably request depositions.* A deposition is the sworn testimony given by a witness outside court. It usually is obtained by one attorney in the presence of the opposing lawyer. There are two types of depositions. A *discovery* deposition is taken for the sole purpose of determining exactly what information the witness can provide. An *evidence* deposition is designed to obtain evidence for use during the trial. Remember, evidence you present in the deposition can be used later to discredit subsequent testimony during the trial.

After evidence is collected and pre-trial motions concluded, the case is scheduled for trial. Of course, the case may never reach the verdict state. The plaintiff may withdraw his complaint, the judge could dismiss the case or a pre-trial settlement could be negotiated.

Keep careful records of the time you spend in preparing your defense, and maintain a complete chronicle of the events which occur before and during the trial.

Because a settlement is often more economical than fighting a claim, your insurance company may wish to settle out of court. Depending upon the insurance agreement, the physician may not have much choice. For example, one insurer obligates the physician to pay any damages awarded which exceed the amount the company was willing to pay in a settlement.

U-M makes progress on SIDS research

University of Michigan scientists believe they have a clue to the cause of crib death.

It appears to be a possible hypersensitivity reaction, evidenced by the presence of antibodies (IgG) in lung tissue of infants who had gone to sleep only to be discovered lifeless an hour or more later.

The significance of the U-M study is the discovery of antibodies in lung tissues of non-traumatic deaths. Children dying suddenly from accident, a fall, or injury do not show antibodies on autopsy.

Of the 1,000 SIDS victims studied and on record with the Wayne County Medical Examiners Office, as many as 60 percent were reported as having had "colds" for several days prior to death.

"Three-quarters of all SIDS deaths were attributed to disease of the respiratory system, with a majority evidencing interstitial pneumonitis," a recent report states.

The study was a cooperative effort between the examiners office and the U-M School of Public Health Department of Epidemiology. Results were recently released in the January 1978 issue of the *Journal of Forensic Medicine.*

Investigators included Nick H. Maverakis, PhD, assistant professor; Warren E. Eveland, PhD, professor emeritus; and W. Wilbur Ackermann, PhD, professor, all of the U-M.

Clara Raven, MD, former deputy chief medical examiner of Wayne County and noted authority of SIDS, was a principal in the study.

"The findings indicate some consistent and therefore essential pathologic process in the lung that must relate (indirectly or directly) to the lethal malfunction of the lung," the report states. It was the discovery of IgG antibody that certified the suspected malfunction.

"There is limited evidence for respiratory viral antigen," the report states.

Infants who died suddenly of unknown, non-traumatic causes, and in whose tissues antibodies were discovered, appeared to be particularly sensitive to the antigen(s) that challenged their immune systems.

"The antibody may be maternal or newborn. The antigen may be endogenous altered lung tissue, or exogenous (viral, toxin, or bacterial) protein, present pre- or post-natally," the report states.

Whether genetic or environmental, inherited or acquired, victims of non-traumatic crib deaths reacted fatally to the antibody-producing agent, even though the antigen itself has yet to be identified.

"But we are certainly working hard on it," states Doctor Ackermann.

The "antibody clue" to SIDS deaths is reinforced by epidemiological evidence which forms a pattern among its victims.

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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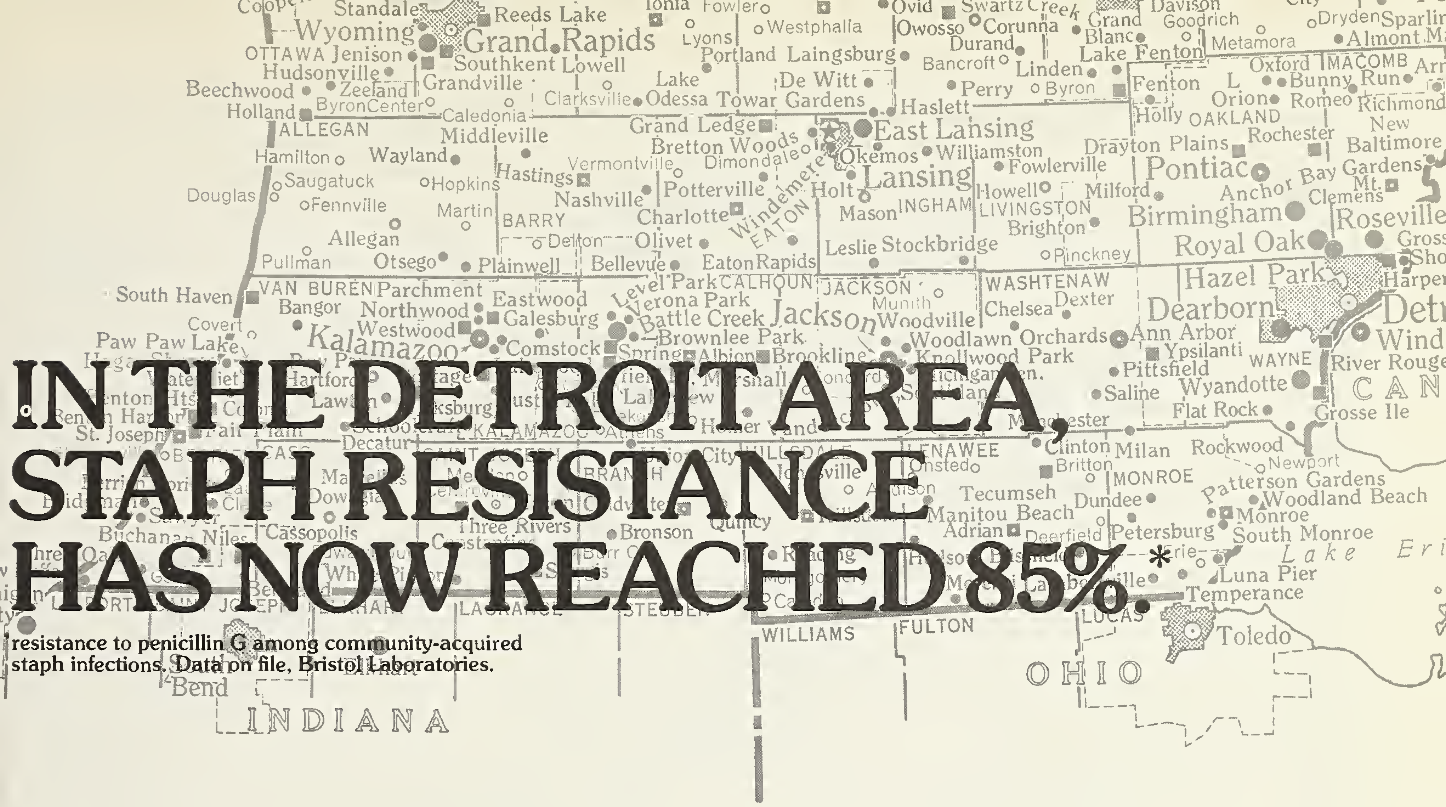
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IN THE DETROIT AREA, STAPH RESISTANCE HAS NOW REACHED 85%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

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- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.

- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.

Please see brief summary
for prescribing information.

Michigan transplant societies: what they do, where they are

By Charles Downs
Special to Michigan Medicine

Kidneys, skin, eyes — they are all sorely needed for transplantation. And to see that they are properly removed for transplant whenever a patient or the next of kin is willing, the attending physician needs to make only one call at any hour, day or night.

From that point on, all the necessary measures will be taken by one or more of Michigan's three organ transplant centers: The Transplantation Society of Michigan, the Michigan Eye Bank (or, in the Upper Peninsula, the Upper Michigan Eye Bank) and the University of Michigan Skin Bank.

Now that Michigan residents can give permission for organ transplants on the back of their driver's licenses, doctors can anticipate that they will be seeing more organ donors than ever before.

Generally, it is up to the attending physician or the hospital to ask the next of kin of a prospective donor for permission for a transplant. Even when the prospective donor has legally given permission, the donor agencies like to have the permission of the next of kin also.

The Transplantation Society of Michigan, 3374 Washtenaw Ave., Ann Arbor, MI 48104. Phone (313) 973-1577. This agency is primarily concerned with kidney transplants, but if the prospective donor wants to donate skin or eyes instead of — or in addition to — kidneys, the Society will see to it that the Eye Bank and the Skin Bank are properly notified.

Gerda H. Lipcaman, secretary-administrator of the Society, urges doctors to remember that at any given time, 150 people in Michigan are awaiting a kidney transplant.

When an attending physician calls the Society about a possible kidney donor, the Society asks for a medical history. Generally the most suitable donors have suffered a cerebral vascular accident, a primary brain tumor or a brain injury through trauma, ischemia or drug overdose, and brain death is present or imminent.

If the prospective donor meets the Society's criteria, a blood sample is requested so that the donor's tissue can be matched with those of patients in need of a transplant. Regardless of type, however, all kidneys are accepted. In the rare cases where there is not a compatible recipient in Michigan, the society has links with regional and national groups that can make a match.

When all conditions are "go," the Society is prepared to send a skilled team to the hospital to perform the nephrectomy. If the hospital is some distance from Ann Arbor, the crew will be flown in, along with a perfusion machine which keeps kidneys in good condition for up to 24 hours and by that time, most donated kidneys will have new owners.

Michigan Eye Bank, University of Michigan Division, Parkview Medical Building, 1000 Wall, Ann Arbor, 48109, phone (313) 764-3262; Wayne State University Division (for Wayne, Macomb and Oakland Counties), 540 East Canfield, Detroit, 48201, phone (313) 577-1329.

Upper Michigan Eye Bank, Marquette General Hospital, 420 West Magnetic Street, Marquette, 49855, phone toll-free (800) 562-9781.

Eye banks are the oldest and probably the best known and utilized of the organ donor agencies, thanks in large part to the active support of Lions Club chapters throughout the country. Nevertheless, there continues to be an urgent need for more eyes. Last year, the two divisions of the Michigan Eye Bank received 612 eyes and arranged for transplantation of 286 corneas. The remaining eyes, which were not suitable for transplantation, were used for research.

Despite these figures, says Patricia Krause, director of the U-M Division, there continues to be a great need for more eyes; at any given time, 50 Michigan residents are in need of corneal transplants.

Once it is established that a prospective donor meets the Eye Bank's criteria, which are very few, a local doctor or, in some cases, a technician (usually a mortician trained by the Eye Bank) will remove the eyes and send them to the bank. Although eyes may be viable four to six hours after death, it is preferred to move them much sooner whenever possible.

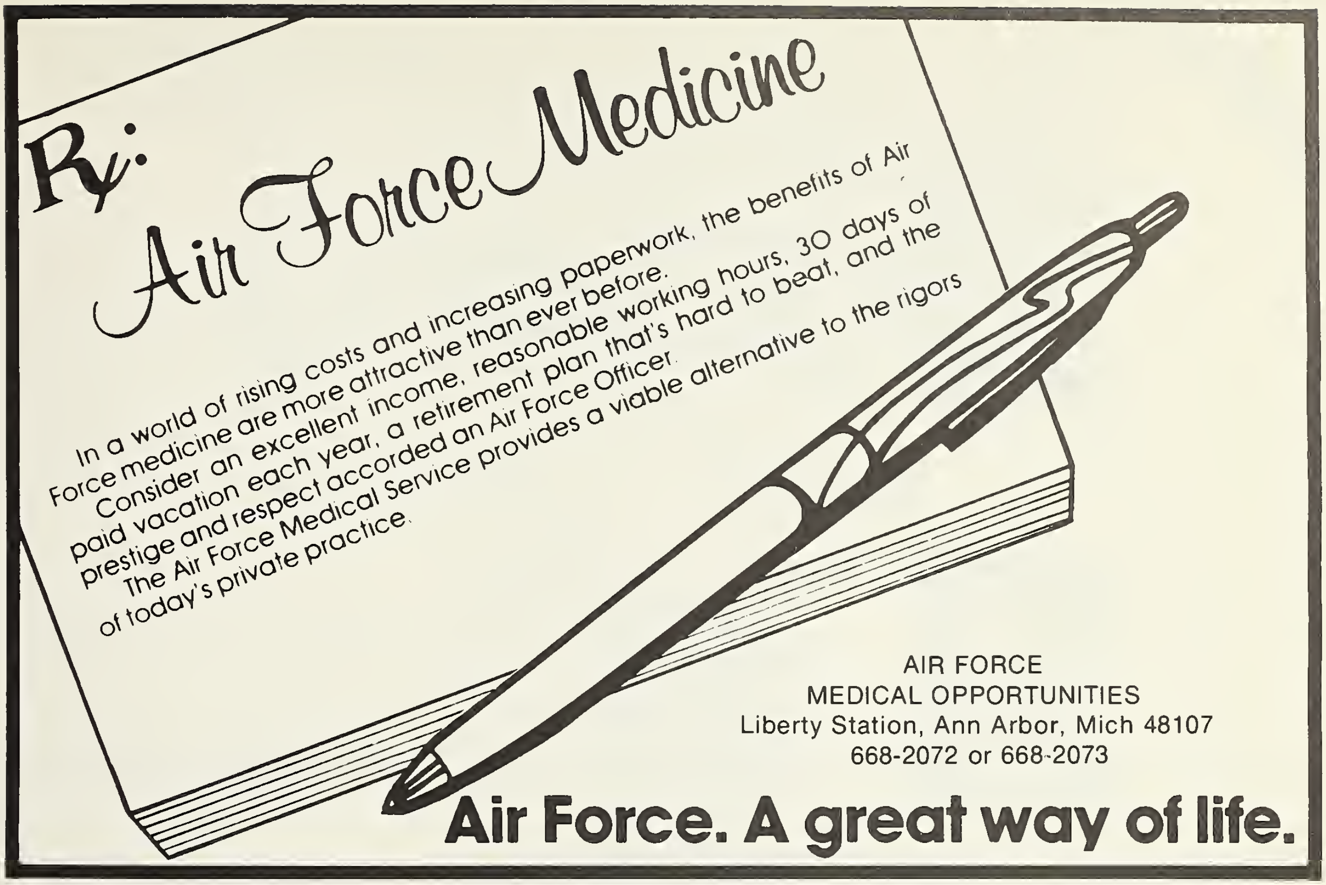
University of Michigan Skin Bank, 3050 Kresge II, U-M Medical Center, Ann Arbor, MI 48109. Phone (313) 668-5838.

Carl Pierson, PhD. director, is on call 24 hours a day, either directly or through a page service to travel to any locale within a 100-mile radius of Ann Arbor in his specially equipped van. Doctor Pierson, a microbiologist and immunologist, is usually aided by one of two assistants who have trained as morticians.

The donor's skin, which remains viable for about 12 hours after death, may be removed at the hospital or funeral home. A .4mm thickness is removed from the back, the buttocks, the thighs and the posterior of the lower legs. Areas that might be visible during a funeral are spared. After about two hours work, the skin is placed in a bottle containing tissue culture fluid and refrigerated. It can be kept for four weeks at four degrees C. or for a year if properly frozen.

Donated skin is used to cover badly burned patients. Although it is eventually rejected by the patient's immune system, the skin provides temporary protection against infection and performs other skin functions such as heat regulation and fluid retention, until additional transplants can be made from the patient's own body.

Doctor Pierson says that he now has 40 to 45 donors per year and could use about 90 or more. He provides not only for the needs of the U-M Burn Center but also for similar units at other area hospitals. Eventually he would like to see the state divided into six geographical areas, each having one hospital serving as a collecting center with a staff on call.



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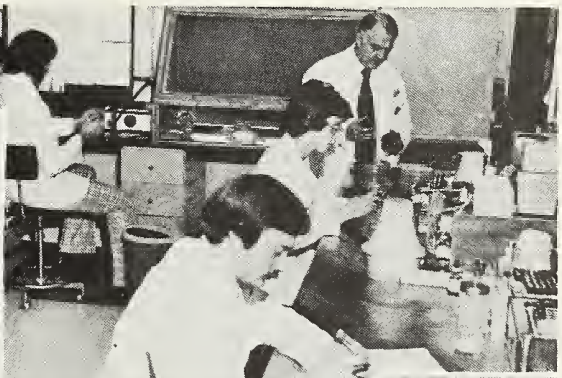

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MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, a sampling of questions, with answers, are printed here. Future issues will carry more.

Mr. Brennan

FOR: Bert Brennan, Director
Michigan Medical Practice Board

"I let my state license lapse last year because I did not do the required CME. How do I get my license back?"

State law provides that the physician whose license has lapsed for failure to complete CME requirements may pay the reregistration fees for each of the years missed, submit evidence of the completion of the required 50 hours of credit for previous year and send all with a letter of explanation to the board's office. If the period of time missed is three years or more, other things are required, such as a new photograph, curriculum vitae, references and letters from other states where the physician is licensed. The entire Medical Practice Board then reviews the application for reregistration.

Doctor Malone

FOR: John Malone, MD, Chairman
MSMS Judicial Commission

"Is it ethical for a physician to add a service charge to bills unpaid after two or three months?"

In April, 1975, the MSMS Judicial Commission reviewed an AMA Judicial Council statement, adopted in December, 1974, which permits a physician to add a service charge on accounts not paid within a reasonable time, with the provision the patient must be notified in advance of the existence of this practice. The MSMS Judicial Commission ruled a printed notice on first statement would be sufficient.

Doctor Reizen

FOR: Maurice Reizen, MD, Director
Michigan Department of Public Health

"What do doctors think of the liquid protein diet that is advertised so much?"

Last August I released the following statement re: liquid protein diets:

"The currently publicized diets using liquid or other protein formula as a means of losing weight can be extremely dangerous if self-prescribed. These diets are near-fasting diets and how any individual might respond to them cannot be predicted. Under no circumstances should a pregnant woman or someone with heart, liver or kidney disease consider such a diet."

Subsequent developments and events force me to recouch my warning in even stronger terms:

"I believe the weight reduction programs using liquid protein products represent a significant potential threat to the health and lives of those using them and would urgently warn Michigan citizens not to buy, use or enroll in any weight control program involving liquid protein diets because of the potential risk to their lives and health."

Doctor Van Goor

FOR: Kornelius Van Goor, MD, Chairman
MSMS Committee on Constitution and Bylaws

"How does one go about dividing a multi-county component society into two societies?"

Physicians who wish to form a separate society must request their MSMS delegate to present a resolution to the House of Delegates to that effect. If the House approves the resolution, amendments to the MSMS Constitution and Bylaws to effect the change are presented. All bylaws amendments must be posted on first reading and laid over to the next year for final adoption. Once the bylaws are changed, an official charter is drawn up and presented. Most recently, Gratiot County physicians formed a new component society, separating from Ionia and Montcalm county societies.

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

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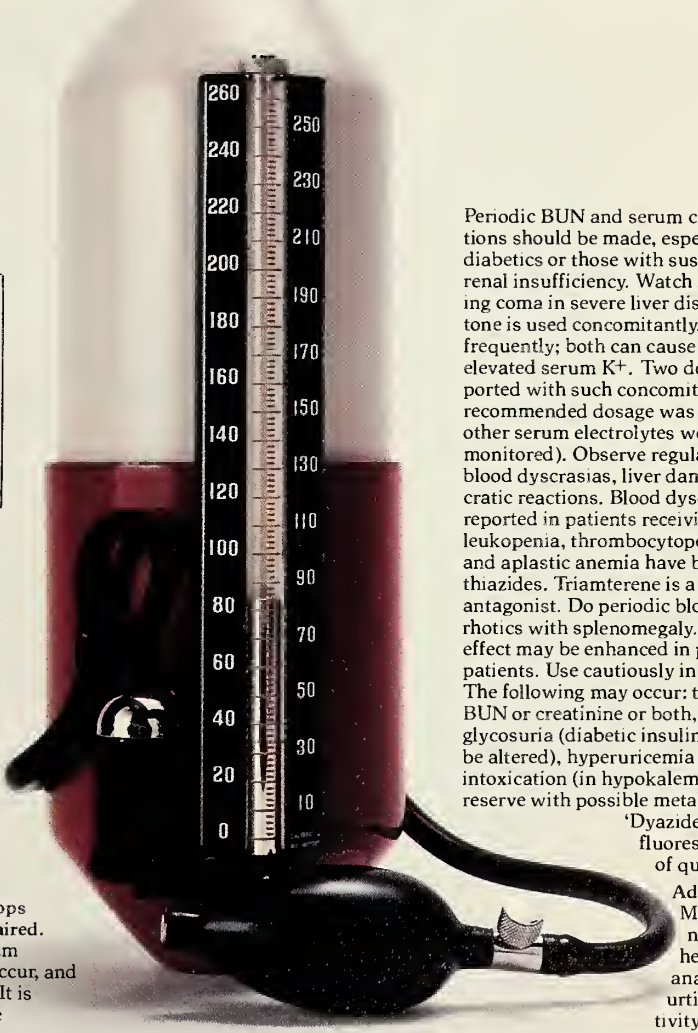

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.*
SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)

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Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is
the test of
all things

ons of potassium ion may cause death through ardiac depression, arrhythmias or arrest. This rug should be used with caution in the presence f cardiac disease.

In hypokalemic states, especially in patients n a salt-free diet, hypochloremic alkalosis is a ossibility that may require chloride as well as otassium supplementation. In these circum- ances, Kaon (potassium gluconate) should be upplemented with chloride. Ammonium chlo- de is an excellent source of chloride ion (18.7 Eq. per Gram), but it should not be used in atients with hepatic cirrhosis where ammonium alts are contraindicated. Other sources for hloride are sodium chloride and Diluted ydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium ycle cation exchange resin, sometimes used to eat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

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Part of the overflow crowd at the 1978 Michigan Conference on Maternal and Perinatal Health. Approximately 1,000 people attended the two-day event.

1978 Maternal Health Conference saw changes

Evaluation forms filled in by participants in the 17th annual Michigan Conference on Maternal and Perinatal Health will be used in deciding whether the same format will be followed for the March 14-15, 1979 Conference.

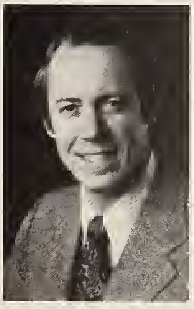
Bruce A. Work, MD, Jr., chairman of this year's Conference (March 8-9, Hyatt Regency Dearborn), said the planning committee will consider the evaluations, review the material and "go from there."

The fact that four half-day sessions during two full days were held this year allowed physicians to attend any half-day and receive continuing medical education credits for it, he explained. Of the estimated 900 physicians, nurses, medical students and others who attended, however, almost all of them registered for both days.

In previous years separate segments of the Conference have been planned by MSMS, Perinatal Association of Michigan and Michigan Section, Nurses Association, American College of Obstetricians and Gynecologists, District V. Under Doctor Work's chairmanship the three sponsoring organizations co-ordinated efforts this year with the theme "Changing Concepts." Presentations ranged from decision-making to the effects of alcohol on a fetus. (This issue of *Michigan Medicine* contains highlights from a few of the lectures selected on the basis of general interest. See pages 300, 302, 304.)

Relaxing during an interview on the second day of the recent Conference (Doctor Work presided over the sessions the first day), the chairman attributed success of the event to the 19 people on the planning committee.

"We began planning early, decided on a theme, program topics and speakers," he said. "After the committee people did their work, MSMS staff put it all together."



Doctor Work

THANK YOU!

The Michigan State Medical Society is very appreciative of the financial support provided this year by the following organizations and firms. All MSMS continuing medical education activities are conducted on a self-supporting basis. Without the financial grants, the Conference registration charge would have been larger.

Once again, MSMS salutes these organizations and firms for helping to further improve maternal and perinatal care in Michigan.

- **Corometrics**
- **Mead Johnson Laboratories**
- **Merck Sharp & Dohme**
- **Michigan Chapter, American Academy of Pediatrics**
- **Michigan Department of Public Health Bureau of Personal Health Services**
- **Ortho Pharmaceutical Corporation**
- **Ross Laboratories**
- **Stryker Corporation**

Much sensitivity needed in dealing with infants' families

By Maryanne Butt
Special feature writer

Physicians, nurses and other health care professionals involved in the care of a newborn infant who must be placed in an intensive care unit should remember that a great degree of sensitivity is necessary in dealing with the parents of these infants.

That point was stressed by Richard P. Gallucci, MD, a Dearborn family physician, at the 1978 Conference on Maternal and Perinatal Health March 8-9 in Dearborn.

Doctor Gallucci urged the nearly 900 participants at the Conference to "always make an effort to be there when you are needed by these parents." At all times, he stressed, health care professionals involved with the family of unhealthy infants must be sensitive to their special needs.

He said it also is important for hospital staff to be factual with the family. The physician should tell the family what he or she knows and they must be told in terms they can understand. "There is no need to be dramatic." Tell the parents the seriousness of the situation, but omit any impending doom in your presentation. The proper choice of words in this type of situation is critical, Doctor Gallucci said.

Ronald L. Poland, MD, director of Neonatal Perinatal Medicine at Children's Hospital, Detroit, said he feels it is wrong to give bad news prematurely. He said the staff at Children's Hospital often have to undo a mother's mourning because she has been told nothing but bad news.

He said at Children's Hospital, the staff involved with the infant and family congregate in a room and discuss the situation with the extended family, or all those involved. He said they ask the parents to explain exactly what they know about their infant's condition. The hospital staff often finds the parents really don't understand the situation, which is then thoroughly explained to them.

The health professionals ask the parents to tell them everything of significance from the pregnancy through the delivery and this way they find out what guilt feelings may exist and can then help to dispel these feelings.

Doctor Poland said at Children's Hospital the health professionals tend to be optimistic with parents, since the statistics on intensive care infants are on the optimistic side.

Doctors Gallucci and Poland were participants in a panel discussion, "Team Approach in Infant Transport." Also participating in the discussion were Noreen O'Brien Brohl, MSW, pediatric instructor at the WSU School of Medicine, and Peggy Malnight, RN, Bronson Methodist Hospital, Kalamazoo.

Parents of unhealthy infants often experience feelings of guilt, anger, resentment and helplessness and it is important for hospital staff to recognize these feelings and allow the parents to grieve, according to Ms. Brohl. If these feelings are not acknowledged and dealt with properly, the anxiety and grief will intensify, she said.

Hospital staff members should not express shock at the variety of ways parents of such infants react, Ms. Brohl said. "If a staff member does not like the way a particular parent acts, the problem is often with that staff member," she said, adding that hospital staff should "be prepared to deal with their own deficiencies."

Ms. Brohl said mothers who admit to being unhappy about the pregnancy usually have more severe guilt feelings. This guilt should not be denied, but rather acknowledged because it is a natural reaction, according to Ms. Brohl. She said to deal with such parents on the basis of, "I know you are feeling guilty and in time it will diminish."

Another important aspect in dealing with grieving parents is, when possible, encouraging the parents to take part in the care of the infant. "Anxiety is energy, so channel that energy into something helpful," Ms. Brohl said. If the infant should die, this will also help ease guilt feelings, she said.

The nurse's role in establishing an early working relationship with parents of unhealthy infants is paramount in the process of parent-infant bonding, according to Ms. Malnight. She said since the nurse is the first person with whom the family makes contact, this initial contact is "very important in establishing the basis for a trusting relationship."

At the time of this initial contact, she said, it is important for the family "to have a basic understanding of the clinical status of the infant, realistic expectations and information about the (neonatal intensive care) unit."

She emphasized the family must also know even though their infant may be transferred to another hospital, their involvement in the baby's care is very important. "Families that become more actively involved in their baby's care feel more useful and have a tendency to visit more frequently."

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Maternal Health Conference speakers Esther Adkins, RN, and Martin B. Wingate, MD.

The birthing room concept and how it works in Kalamazoo

By Willah Weddon
Special to **Michigan Medicine**

"The concept of the birthing room was to make the hospital atmosphere home-like and natural, so the family could join in as much as possible," according to Martin B. Wingate, MD, professor of obstetrics and gynecology and director of maternal-fetal medicine, Maternity Hospital, Buffalo, NY. "It appeared in Europe many years ago . . . particularly in Holland."

Doctor Wingate was one of the most popular speakers at the 1978 Michigan Conference on Maternal and Perinatal Health March 8-9 in Dearborn.

He is enthusiastic about a birthing room or center "as long as it is within reach of highly sophisticated intervention, should it be required."

'No way . . . at home'

Doctor Wingate draws a firm line, however, against home deliveries.

"Home births have a much higher number of perinatal deaths," he cautioned. "There is no way I would have my daughter, my wife or anyone deliver her baby at home."

Until a few years ago, when he practiced in England, he said only 40 percent of the births took place in hospitals. Today it is nearer 85 percent. In Buffalo, there are "Prepared Childbirth Rooms" which provide pleasant surroundings for an expectant mother. Here the father stays with the expectant mother and, despite objections from some pediatricians, older siblings are also allowed to attend the event if they want to and have been prepared.

"We sit them at the mother's head, so they can see the baby held up after it's born," Doctor Wingate said. The room is decorated attractively and staff members are supportive. The couple often have champagne with their dinner in the evening following the birth, as the new mother and infant are kept in the room about six hours.

External monitoring is continuous throughout, with the parents' knowledge, for the protection of the infant.

'Good way to deliver'

"If everyone is prepared, it is a good way to deliver," Doctor Wingate pointed out. "This means being prepared for failure, too, because if the mother has to be transferred there is a psychological let-down."

This does not happen often, however. From December 1976 to December 1977, 79 percent of the 453 patients in his birthing room delivered spontaneously and 96.4 percent delivered "extremely well."

Admitting some things did go wrong, such as having to transfer a few women for Caesarean sections, the facilities were available for their care. On the whole, Doctor Wingate said his experience in the birthing room has been very successful. For one thing, there have been no perinatal deaths.

"Home delivery, on the other hand, is such a dangerous situation," and he pointed to the much higher number of deaths under these circumstances. He cited the latest statistics from the American College of Obstetricians and Gynecologists, as follows:

Survey on perinatal mortality of 1976 home births compared to hospitals

	At home	In hospital
California	25	9.9
Hawaii	34.4	9.6
Oregon	17	9.7
Iowa	63.6	18.4
Kansas	103.7	19.9

(per 1,000 births)

Birthing center in Kalamazoo

When it was decided to create a Birthing Center in the Bronson Methodist Hospital, Kalamazoo, several forces joined together and held meetings regularly in preparation.

"Nurses and physicians talked it over, the hospital administration agreed to help and we submitted our proposal to the Michigan Department of Public Health," Esther Adkins,

(Continued on page 304)

Michigan State Medical Society

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James W. Hanson, MD, left, Iowa City, speaker on fetal alcohol syndrome, was interviewed by Detroit's Channel 7 Science Editor Jerry Hodak, while another participant and a camera crew member looked on.

R.N., Head Nurse of the Labor and Delivery Unit, described their course of action.

Mrs. Adkins also spoke at the Maternal and Perinatal Health Conference. Bronson's priorities in the birthing room, she said, were to provide equipment for the safety and care of mothers and infants, and to meet hospital and department of health requirements.

How to furnish their birthing room? They decided "it would be the people in the room that would make the difference rather than the furnishings" and made only a few purchases. An infant warmer, with no blinding light, and a sleeper sofa for the person staying with the woman in labor, were the major items added to a regular hospital room.

Use of the room was based on the patient's request, made in the physician's office and signed by the patient when she gave her consent. (The latter based on an anticipated normal labor and delivery.) There was to be reasonable open visitation, maximal bonding of the family unit and the choice of early discharge.

Confronted with the possibility of early discharges, arrangements were made with the Visiting Nurses Association and the Kalamazoo County Public Health Nurses to serve as a back-up crew and look in on the babies at their homes, Mrs. Adkins said. This, plus the fact that the infants are thoroughly checked for a couple days in the hospital, gained them the cooperation of pediatricians.

The Kalamazoo experience

The extra cost to the hospital has been insignificant, she continued, and remained about the same for the patient as it was previously. It is only less expensive for them if they go home earlier. Their overall hospital stay, however, has averaged 3.1 days while others average 4.3 days.

During the first six months the birthing room was in operation, July to December 31, 1977, 25 families used the room. The shortest stay was seven hours and the longest was six days.

The chief morbidity to mothers was perineal lacerations. A number of babies had physiological jaundice and one had a minor hematoma.

"I'm not sure how long we're going to continue this method," Mrs. Adkins commented. "We've changed the other rules so now."

They have designed a unit to have babies in a crib beside their mothers in the recovery room, fathers are no longer "sent to the hall" and siblings are allowed in, too, to hold the new baby.

It may be that the advantages of a birthing room can be incorporated into general use and any disadvantages eliminated this way, Mrs. Adkins said.

Public Health Association meeting June 6-9 in Dearborn

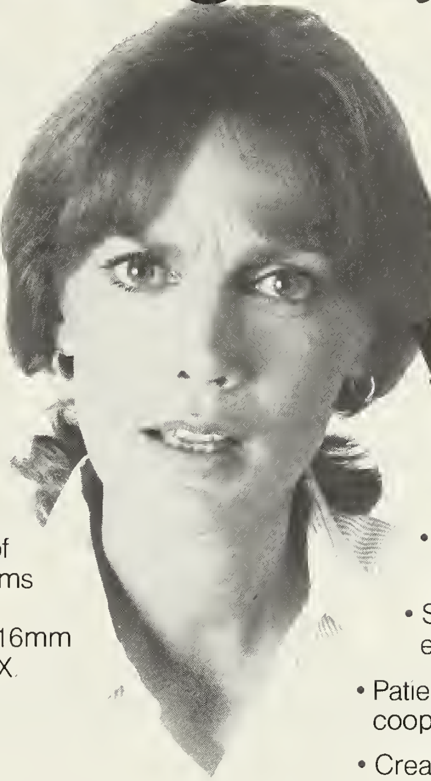
The annual conference of the Michigan Public Health Association, combining both business and continuing education sessions, is planned June 6-9 at the Hyatt Regency Dearborn.

Four hours of Category I credit are available to physicians who register for the June 6 afternoon sessions. Those sessions will deal with new pneumococcal vaccines, and concepts of prevention applied to mental health. Speakers will be David Bentley, chief of infectious diseases, Monroe Community Hospital, New York, and Gardner C. Quarton, MD, professor of psychiatry and director of the Mental Health Research Institute, The University of Michigan.

The MPHA house of delegates will meet during the three-day program, and other sessions are planned on cost effectiveness, communications, the news media, corporation's health programs, environmental health trends, patients' rights and responsibilities and teenage sexuality. An awards banquet is planned Thursday evening, June 8.

Further information is available from the MPHA, 403 Seymour Ave., Lansing, 48914.

"I still don't understand. Can you explain it again, Doctor?"



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Meetings

(See also listing of Category I programs on page 279)

May 18 — 15th Annual Legislative Forum, sponsored by Michigan League for Human Services, contact: the League office at 200 Mill St., Lansing, 48933, or phone 517/487-5436.

May 24-26 — 1978 Medical Staff/Trustee/Administrator Forum, Boyne Mountain Lodge, Boyne Falls, contact: Michael Nolan, Michigan Hospital Association, 2213 E. Grand River, Lansing, 48912, 517/484-7441.

May 25 — Western Michigan PSRO Annual 1978 Meeting, Hospitality Inn, Grand Rapids, contact: Western Michigan PSRO, 616/942-6090.

June 6-9 — Michigan Public Health Association Annual Meeting, Hyatt Regency Dearborn, contact: Executive Director, MPHA, 403 Seymour Ave., Lansing, 48914, 517/484-3044.

June 17-22 — AMA Annual Meeting, St. Louis.

July 8 — MSMS Council, Deer Lake, contact: Warren Tryloff, MSMS director.

July 10-14 — International Automotive-Medical Meeting, sponsored by the American Association for Automotive Medicine and the International Association for Accident and Traffic Medicine, at the University of Michigan, Ann Arbor, contact: AAAM Secretariat, P.O. Box 222, Morton Grove, IL 60053.

July 29-Aug. 2 — 32nd Annual Convention and Scientific Assembly, Michigan Academy of Family Physicians, Sugar Loaf Village, Cedar, contact: Rita Feldkamp, 933 Wing St., Plymouth, 48170.

Aug. 28-Nov. 22 — Fall Medical Review Program for FLEX, ECFMG and VQE, Oakland University, Rochester, cost: $923, contact: Medical Review Program, Center for Health Sciences, Oakland University, Rochester, 48063, 313/377-3563.

Sept. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

Nov. 1 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

***Nov. 7-9* — MSMS Annual Scientific Meeting, Detroit Plaza Hotel, contact: Herb Auer, MSMS headquarters.**

Dec. 2-6 — AMA House of Delegates Interim Meeting, Chicago.

Dec. 7 — AMA Winter Scientific Meeting, Las Vegas.

Dec. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Disciplinary actions of the Medical Practice Board taken Jan. 4, Feb. 16, and March 8, 1978

The following actions of the Michigan Medical Practice Board are taken from an official memorandum to MSMS and are not editorialized.

Robert M. Nixon, MD, Bay City. Doctor Nixon's limited license was amended to allow him full medical licensure with the stipulation he practice without the privilege of a DEA or CSR permit.

Walter Hermsworth Gardiner, MD, Detroit. License suspended for period of 30 days for violation of the Medical Practice Act. Unprofessional conduct. Suspension to become effective February 16, 1978.

Albert Lucian Laura, MD, Livonia. Permanent surrender of his Michigan controlled substance registration.

Richard W. Sundling, MD, Birmingham. License restored to practice medicine under the limited license section. Practice limited to a Board approved program. Doctor not permitted to have a DEA or CSR permit.

Milton Palmer, MD, Detroit. License was restored with stipulation. Respondent shall permanently surrender his federal and state controlled substances registration to the issuing agency and shall never reapply for such registration.

Pedro Berdayes, MD, Detroit. Issued a limited license.

How much physicians really make and earn

What about the true nature of physicians' incomes?

A news release from HEW says the "typical" physician worked 58 hours a week in 1975 and earned $53,600 after business expenses. The release mentioned only some of the statistics the federal government assembled in 1975 on work and its rewards.

HEW didn't mention that if a physician worked 58 hours a week, he was working 61 percent longer hours than the average American. According to the *Statistical Abstract of the U.S.*, the average workweek in 1975 was 36.1 hours.

The typical physician's income would work out to about $33,400 if he had worked the average 36.1-hour week (or $36,900, if based on a 40-hour week).

From his or her net earnings, a doctor must pay for his or her own "fringe" benefits. Employed workers usually have these benefits paid, at least in part, by their employer.

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News

By Katie Brewbaker, MSMS staff

Ann Arbor internist **Robert B. Carbeck, MD,** is the new president of the Association for Hospital Medical Education.

Alfred B. Swanson, MD, of Grand Rapids, is new secretary-general of the International Federation of Societies for Surgery of the Hand and president-elect of the American Society for Surgery of the Hand.

The American Academy of Ophthalmology and Otolaryngology, Inc., will present its Award of Merit to **Luiz F. P. DeMoura, MD,** Mt. Clemens, at the Academy's annual meeting.

Four physicians have been selected for special recognition for their "dedication, interest, and ability in the art of teaching" by students from the Upper Peninsula Medical Education Program. Honored were Doctors **Paul T. Werner** and **Raymond Hockstad** of Escanaba, **Robert Stelle,** Crystal Falls, and **Carl Hammerstrom,** Marquette.

C. John Tupper, MD, former assistant dean at the University of Michigan Medical School and former scientific editor of *Michigan Medicine* is the new president-elect of the California Medical Association. He is dean of the University of California School of Medicine, Davis.

Robert S. Nixon, MD, will serve as acting medical director of the Bay County Health Department.

Internal medicine professor at the University of Michigan, **Park W. Willis, III, MD,** has been promoted to the rank of rear admiral in the United States Navy.

Wayne State University School of Medicine ophthalmologist, **Dong H. Shin, MD,** is part of a team of scientists that has completed work on a mechanical device to reduce complications for glaucoma surgical patients. The Pressure Reduction and Regulation System has been used by Doctor Shin in six operations at the Kresge Eye Institute and all the patients are doing well.

Doctor Bauer

Doctor Stehman

Doctor Willis

Doctor Vincent

Governor William G. Milliken has appointed Doctor **Vernon A. Stehman** as acting director of the Michigan Department of Mental Health. Doctor Stehman, a psychiatrist, has served in the department for 22 years and at the time of his appointment was head of the departments' Prevention, Treatment, and Normalization System.

Theodore I. Bauer, MD, Lansing physician for 50 years is recipient of the "Community Service Award" of the Lansing Regional Chamber of Commerce at its 66th annual meeting. Doctor Bauer has served as a director of the chamber and president of the Ingham County Medical Society, among his many other community activities.

Psychiatrist **Michael R. Liepman, MD,** is new "Career Teacher in Alcoholism and Drug Abuse" at the University of Michigan Medical School. Backed by a three-year grant from the National Institute of Alcohol Abuse and Alcoholism, the U-M is one of 45 medical schools in the United States chosen for this program.

Charles C. Vincent, MD, is new associate dean for student affairs at the WSU Medical School. Doctor Vincent formerly was assistant dean for admissions. He will continue as an associate professor of gynecology and obstetrics in the Medical School.

Chairman of the University of Michigan's new department of family practice is **Terence C. Davies, MD.** Doctor Davies came to the U-M from the University of South Alabama College of Medicine in Mobile where he was professor and associate chairman of the family practice department.

Michigan authors . . .

Pange L. Man, MD, and **Calvin H. Chen, MD,** of Northville State Hospital, co-authored an article on "Plasma Levels of Neuroleptics Vs. Clinical Response" in *Psychosomatics.*

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Deaths

Cornelius E. Dunn, MD
St. Clair Shores

Cornelius E. Dunn, MD, 81, St. Clair Shores, died March 22. A graduate of Wayne State University School of Medicine, Doctor Dunn was on the surgical staff of Providence, Saratoga and East Side General hospitals. He was a member of the American College of Surgeons and International College of Surgeons, and was past president of the Wayne State University Medical Alumni.

William N. Edmonds, MD
Detroit

William N. Edmonds, MD, Detroit, died on March 1 at the age of 88. Doctor Edmonds graduated from the Loyola University Medical School, Chicago. He served on the staff of Hutzel Hospital, Detroit, specializing in gynecology and obstetrics.

Robert F. Hague, MD
Flint

Robert F. Hague, MD, Flint, died Feb. 27 at the age of 83. A native of Copenhagen, Denmark, Doctor Hague graduated from the University of Michigan School of Medicine. The proctologist and surgeon was a former Genesee County coroner and medical director for the Flint Civil Defense Council. He was a member of the Michigan Proctological Society.

David Migdoll, MD
Southfield

David Migdoll, MD, Southfield, died Jan. 20 at the age of 66. Doctor Migdoll was affiliated with Plymouth General and Lakeside hospitals. He graduated from Wayne State University School of Medicine.

Albert P. Murphy, MD
Saginaw

Albert P. Murphy, MD, Saginaw, 71, died March 21. A family physician, Doctor Murphy was on the staff at St. Mary's Hospital, and on the Courtesy Staff at Saginaw General and St. Luke's hospitals. He was a charter member of the American Association of Family Practice. He was a past secretary of Saginaw County Medical Society.

John K. Ormond, MD
Ann Arbor

John K. Ormond, MD, Ann Arbor, died Feb. 25 at the age of 91. Doctor Ormond received his medical degree from Johns Hopkins University and was on the staff of Ford Hospital, Detroit, where he was surgeon in charge of urology. He spent time in India as a medical missionary, supervising the establishment of training programs in urology. His medical affiliations included the International College of Surgeons, the General Surgical Association, the American Association of Genito-Urinary Surgeons, the American Urological Association and the American College of Surgeons.

Fred R. Thacker, MD
Frankfort

Fred R. Thacker, MD, 75, of Frankfort, died Feb. 20. Doctor Thacker graduated from the University of Chicago, Rush Medical College. He was a member of the Michigan Academy of Family Physicians.

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For further details call John Levin at (517) 351-4481. Submit resumes to John Levin, Executive Director, Michigan Region VI PSRO, 5030 Northwind Drive, Suite 205, East Lansing, MI 48823.

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FAMILY PRACTITIONER AND/OR PEDIATRICIAN needed in South Haven, a Lake Michigan community. Office suites available in a new professional building adjacent to a well-staffed and expanding community hospital. Call collect and visit South Haven: David Fenske, MD, Office 616/637-5925, Home 616/227-3667.

ONCOLOGIST — A modern, progressive 488-bed hospital located in mid-Michigan has just completed construction of an Oncology Center (Clinac-18 Linear Accelerator and cobalt therapy), and is seeking a board certified or board eligible Oncologist. Opportunity is ideal for an individual with experience as a director or assistant director in an established oncology program with an interest in setting up an oncology private practice.

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PUBLIC HEALTH PHYSICIAN — $34,994-$45,372. MINIMUM REQUIREMENTS: Possession of a master's degree in public health and a license to practice medicine or osteopathic medicine and surgery in Michigan. Applicant will provide leadership in developing a public health residency program and serve as preceptor for nonprepared physicians entering public health administration. The work will involve working with State and local health departments, hospitals, medical schools and schools of public health. A real opportunity and challenge for one wishing to make an impact upon the future course of public health and preventive medicine.

For further details, please send correspondence and Social Security number to: Public Health Physician-A, P.O. Box 30001, Lansing, MI 48909. AN EQUAL OPPORTUNITY EMPLOYER.

DIRECTOR OF EDUCATION IN INTERNAL MEDICINE. A certified internist or subspecialist is needed for an administrative and teaching position in an Internal Medicine residency program affiliated with Michigan State University College of Human Medicine and Hurley Medical Center. McLaren General Hospital is a 469 bed, progressive, acute care hospital with general surgery, internal medicine, orthopedic, ob-gyn, and psychiatric training, and an undergraduate teaching program. Salary negotiable. Community offers excellent recreational and cultural opportunities. Inquiries to: Search Committee, c/o Mr. Gary R. Peterson, McLaren General Hospital, 401 Ballenger Highway, Flint, Michigan 48502, 313/762-2345 or B. S. Farah, MD, Chairman, Dept. of Internal Medicine, McLaren General Hospital, 401 S. Ballenger Highway, Flint, Michigan, 48502, 313/235-6663.

INTERNISTS FOR PRIMARY CARE UNIT, Hospital based practice in Ann Arbor, Michigan available July 1, 1978. Faculty appointment with house staff teaching through affiliation with the University of Michigan. Salary to $40,000 plus, depending on qualifications, with Federal Civil Service benefits; an equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, MI 48105.

INTERNISTS — FAMILY PRACTITIONERS, positions available September 1, 1978 at new VA Outpatient Clinic located in Toledo, Ohio. Salary to $40,000 plus, depending on qualifications, with Federal Civil Service benefits: an equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, MI 48105.

MEDICAL DIRECTOR for new VA Outpatient Clinic opening in Toledo, Ohio September 1978. Desire IBIM and demonstrated administrative ability. Salary to $50,000, depending on qualifications, with Federal Civil Service benefits; an equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, MI 48105.

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GENERAL PRACTITIONER — to provide medical care in a small state hospital for the mentally ill and mentally retarded located in Michigan's beautiful Upper Peninsula. Current salary $37,855 plus a liberal Civil Service benefit package. Write Steven A. Meyers, M.D., Chief of Clinical Affairs, Newberry Regional Mental Health Center, Newberry, MI 49868.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park, there are openings for physicians board qualified as internists, family physicians or psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently over forty thousand per year, plus 23 percent fringe benefits, including life, accident, long term disability, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7789.

MEDICAL DIRECTOR: For 206-bed chronic disease facility to work in a dynamic, challenging program with a progressive medical and paramedical team. Salary $43,000. Excellent fringe benefits as an employee of Macomb County: generous retirement program; longevity compensation; paid liability and professional malpractice; Blue Cross/Blue Shield with prescription rider; life insurance; 13¼ holidays; sick leave. Qualifications: Physician licensed to practice in Michigan. Special emphasis will be placed on additional qualifications specific to a chronic disease and long-term rehabilitation program. Contact Raymond D. Pietrzak, Administrator, Martha T. Berry Memorial Medical Care Facility, 43533 Elizabeth Road, Mt. Clemens, MI 48043. Phone 313/469-5623, ext. 24.

FAMILY PRACTICE PHYSICIAN OR INTERNIST, Applicant must be interested in General Family Medicine for five Integrated Clinics in city and suburbs. Complete laboratory and nuclear medicine. Foreign graduates must have state license. Liberal salary. Call or write TRAIL CLINICS, P.C., Cindy Papuga, Clinic Secretary, 18254 Livernois, Detroit, MI 48221, 313/861-4400.

Positions wanted

SANDRA L. WISMER, MEDICAL ILLUSTRATOR. Services include: medical illustration, graphic design, biophotography, and three-dimensional teaching aids. Address: 1985 Lake Lansing Road, Apt. 23, Haslett, MI 48840. Phone: 517/339-3170. Background: B.S. in Medical Illustration from the Ohio State University, Columbus, Ohio. Currently in a Medical Illustration position at Michigan State University. Available for work on a freelance basis. Please call after 5:00 p.m.

PHYSICIAN'S ASSISTANT — primary care, is seeking position beginning summer '78 after 3½ years with two family practice MDs. B. of S. in medicine degree from Western Michigan University. Interested in family practice, administrative, or teaching. For resume or information: John Kircher, 2135 Seventh, Bay City, MI 48706, 517/892-4953.

Miscellaneous

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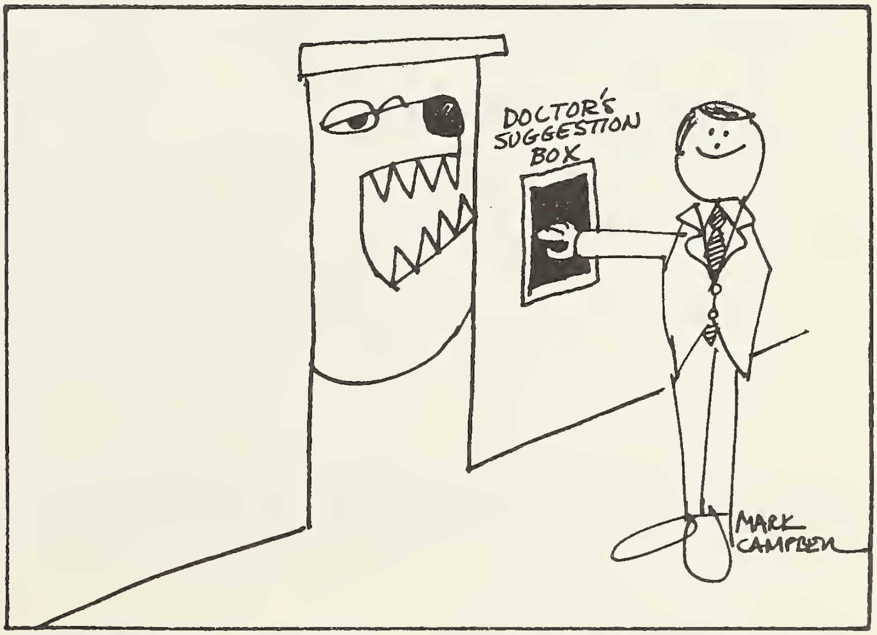

(Doctor Campbell is completing an internal medicine residency in Grand Rapids this spring.)

President's page

Our health care must meet needs and permit us to function well

In this, his first article for Michigan Medicine *as 1978-79 president of the Michigan State Medical Society, Louis E. Heideman, MD, Birmingham, offers his thoughts about medical practice in the future. The article is excerpted from Doctor Heideman's inaugural address at the 1978 MSMS House of Delegates meeting May 5-7 in Dearborn.*

As we look to the future, there are some realities we must recognize:

- Change will occur. Our goal should be improved capacity and improved care. Only we can provide the insights of medicine to the process.
- Collective problem identification and problem solving will be with us for the next 15 to 20 years. We must acquire the techniques for functioning effectively in this environment without sacrificing our basic professional character. And we must become as knowledgeable and involved in the social and economic factors of society as we are in medicine.

Organization for medical care delivery in the future must take into account patient expectations. These include continuity of care for most patients, the feeling that costs are fair, that patients are receiving individual attention, and this is reasonably available to them. I think we have gone too far in dropping the house call, this being a major bone of contention with patients and a focus for their resentments.

- There will be a continuing development of the group practice largely because we find it an easier way to practice. This should represent no real threat. Many of us can function more effectively in such a setting. Many patients prefer the relative anonymity of the group setting to the more intense one-to-one relationship. We must develop techniques for service to remote areas.
- On the economic front we can expect increasing efforts to control expenditures for physician services. There is consideration of charging the physician for inappropriate use of facilities, procedures, and the laboratories, with inappropriateness apparently to be determined outside the profession as we cannot be trusted to police ourselves.

I would very much prefer to eliminate all third parties in the physician-patient relationship. Let the patient pay the physician and be reimbursed by the third party. Certainly, this involves the patient in decision-making. It avoids the semblance of any price fixing or anti-trust activity. It avoids putting the physician and patient in an adversary role — a most undesirable relationship which is becoming more and more evident in some of the current cost control efforts.

Louis E. Heideman, MD
MSMS president

- As for our political future, I do not expect any major change soon. We must have increased support for AMPAC and MDPAC. We must further refine our skills in these areas and recognize at times we will be further ahead to support a qualified candidate who does not consistently see eye-to-eye with us rather than a hack who can be easily influenced. Unfortunately, the latter also is all too easily converted.

Each of us in medicine must become more familiar with pending issues and present a balanced view to our patients so they can make an educated decision. We must be prepared to spend a limited amount of time each day in discussion of these issues with only one patient. The cumulative effect would be to significantly change our patients' perspective.

Repeated studies and polls show we have a great deal of respect and confidence coupled with great satisfaction. We must use these assets wisely and effectively to help develop a structure for health care delivery for all the people of our land which meets their requirements, and which permits us to function effectively in service to them.

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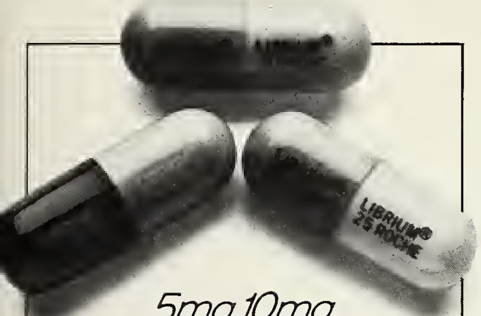

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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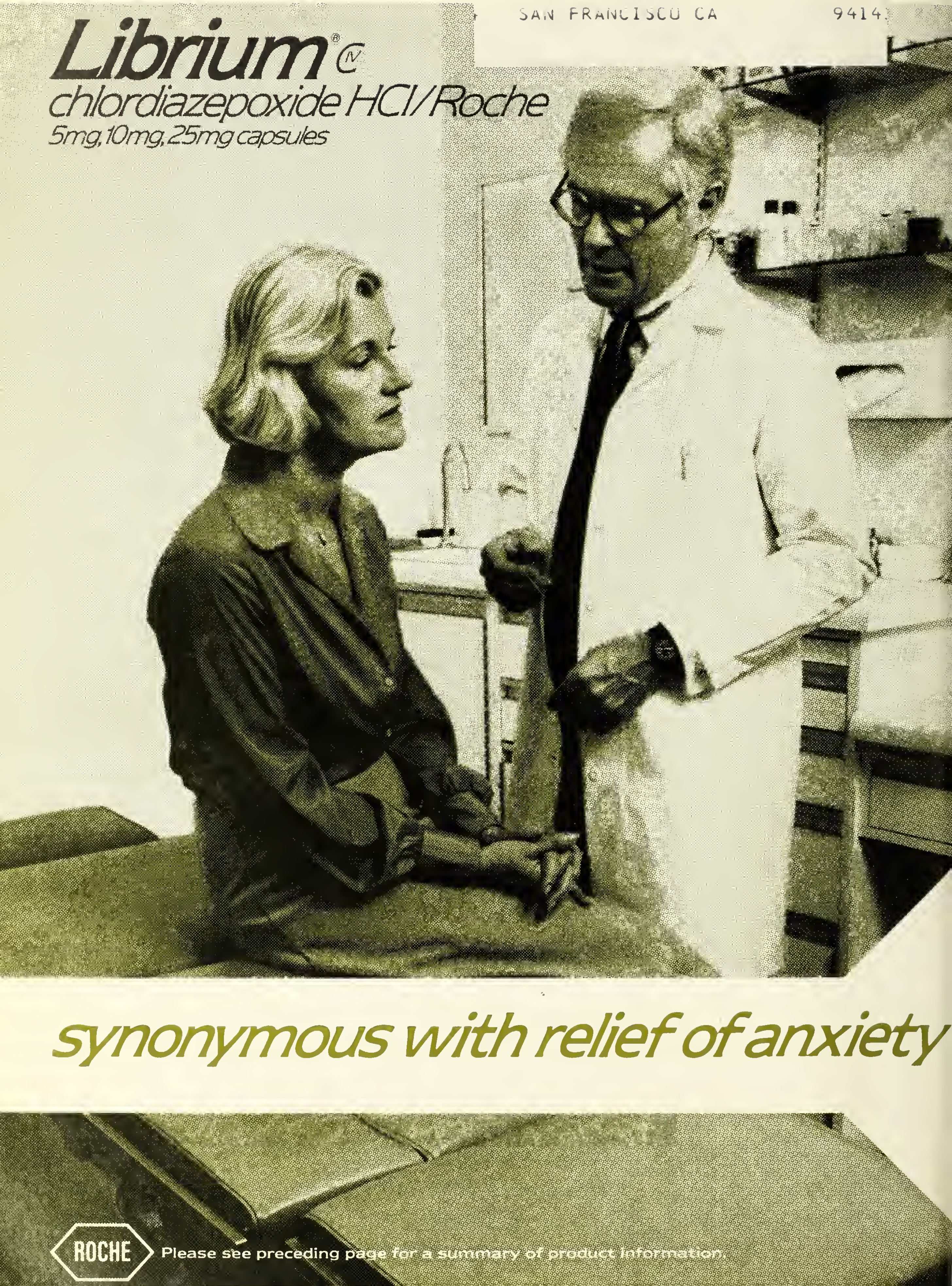
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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 14 MAY 15, 1978

This issue of Medigram is important because....

1) It contains a brief report of the actions of the MSMS House of Delegates May 5-7 in Dearborn.

2) It includes a four-page insert on current medical legislation.

3) It includes an important petition and explanatory brochure opposing taxation.

octor Heideman nstalled; Doctor riffin elected

ouis E. Heideman, MD, etroit pediatrician, was nstalled Saturday, May 6, as 978-79 president of the Mich-gan State Medical Society. he ceremonies took place at he Hyatt Regency Dearborn uring the 1978 MSMS House of elegates meeting.

octor Heideman, long active n MSMS and the Wayne County edical Society, succeeds ernon V. Bass, MD, Saginaw bstetrician-gynecologist.

amed president-elect of MSMS s Ernest P. Griffin Jr., MD, lint radiologist who has erved as chairman of The SMS Council since May, 1975. amed to succeed him as MSMS ouncil chairman is Louis R. ako, MD, Dearborn Heights amily MD who has served as ouncil vice chairman the ast two years. James H. isdel, MD, Port Huron bstetrician-gynecologist, is ew Council vice chairman.

peaker of the MSMS House of elegates James D. Fryfogle, D, Southfield, and vice peaker David Siegel, MD, ansing, were re-elected. obert M. Leitch, MD, Battle reek, was named secretary to ucceed long-time MSMS

(Cont. on back page)

MSMS delegates approve proposed MSMS/BCBSM agreement

A well-informed MSMS House of Delegates took actions in record time during the 113th annual session of the MSMS House of Delegates May 5-7 in Dearborn.

The 200 seated delegates and alternates dealt with 63 resolutions in approximately four hours Sunday May 7 at the Hyatt Regency Dearborn Hotel. Little debate or discussion was heard, with the delegates primarily accepting the recommendations of the reference committees which held lively hearings Saturday morning.

The delegates approved the terms, as presented by the MSMS Negotiations Committee, of a proposed agreement now being forged between physicians and the Blues after a year of confrontations over the Blues' reimbursement changes in the name of cost control.

During reference committee sessions, the delegates considered the recommendations of the National Commission on Health Care Costs and offered their views to Michigan delegates to the AMA present in each reference committee. The Michigan delegates will take those views to the AMA annual convention in June in St. Louis, where a national position will be formed. Here is a brief report of what the MSMS delegates did May 5-7:

The Blues/negotiations

THE HOUSE APPROVED the proposed MSMS/BCBSM agreement to "work toward a better health care system." The terms include BCBSM management's offer to recommend May 11 to the BCBSM board immediate authorization to implement a statewide screen for all physicians to be effective July 1. Effective May 7, MSMS now urges cooperation on the Michigan Medical Claims Form completion and discontinues its efforts to urge physician departicipation.

JUN 1 - 1978

Each group will appoint a committee to develop an overall plan including action steps and timetable by July 1. They will work to carry out four basic principles:

1) An effective program to control health care costs should be implemented as soon as possible. A prospective system should be designed to control aggregate payment for professional health care services and an equitable system to implement such a program should be developed by Jan. 1, 1979.

2) There will be an effective service benefit program.

3) Reimbursement policy shall be designed to incorporate payment mechanisms which are supportive of the service benefit and cost containment principles.

4) All physicians will be treated equally within a reimbursement system that is consistent with the above principles.

THE HOUSE TOOK NO ACTION on resolutions to make BCBSM an indemnity company, though that remains a possible MSMS goal; it rejected a resolution to promote differences in reimbursement payments to specialists and non-specialists for the same services, and referred to the AMA delegation a resolution that regionalization of fees be eliminated by all health insurance carriers.

THE HOUSE REFERRED to The Council resolutions for the formation of an independent mutual hospital insurance company, for formation of a physicians' union for formal bargaining purposes, and for support of the current otolaryngologists' suit against the Blues.

Legislation

THE HOUSE STRONGLY OPPOSED certificate of need regulation for physicians' offices, and resolved to so inform legislators, congressmen and the AMA.

THE HOUSE TOOK NO ACTION on a statewide fee schedule for Medicaid, so as not to jeopardize negotiations with the Blues.

THE HOUSE VOTED to work to abolish the Visa Qualifying Exam requirement for FMGs currently licensed to practice in any given state and who are seeking immigration, and to support graduate education programs which accept qualified candidates regardless of race, creed, color or national origin.

THE HOUSE REFERRED to The Council a resolution to inform President Carter and HEW Secretary Califano of MSMS concern over the excessive expenses of taxpayers' money on PSRO programs.

Medical care costs

THE HOUSE REAFFIRMED the MSMS position that the patient should pay directly at least a portion of medical care costs.

THE HOUSE APPROVED a resolution that The MSMS Council consider establishing a study commission on health care cost components to be made up of public, industry, labor, government and health industry representatives.

THE HOUSE RESOLVED that MSMS encourage fair market competition between HMOs and fee-for-service practice; that HMOs should provide full medical services and maximum care for the full range of patient population; that all costs of operating HMOs should be included in comparisons between fee-for-service practice; and that studies should be carried out to compare cost-effectiveness of HMOs with fee-for-service practice.

THE HOUSE APPROVED a resolution supporting the efforts of the MSMS Task Force on Medical Care Costs and requesting dissemination of their data after MSMS Council approval.

Miscellaneous

THE HOUSE DISAPPROVED the proposed changes in the AMA Code of Ethics, which are intended to modernize the language of the code, and asked the MSMS delegation to oppose the proposed new code in June.

HOUSE BILL 4070 — PUBLIC HEALTH STATUTES REVISION PROJECT (PHSRP)

SPONSORED BY: Rep. Kehres

SUMMARY: This 450-page bill is the culmination of efforts by the Legislature and interested professional groups to compile and codify the public health statutes into one public health code for the entire State. This bill includes the procedure for licensure and certification of health professionals.

STATUS: Senate Appropriations with substitute.

MSMS POSITION: MSMS supports this bill with three amendments.

HOUSE BILL 4491 — REDUCTION OF HOSPITAL BEDS

SPONSORED BY: Rep. Kehres

SUMMARY: This bill establishes criteria and guidelines for the reduction of excess hospital beds. The bill provides that the Department of Public Health shall annually publish a list of health facility service areas which have an excess of beds. The HSA within 6 months shall develop a plan for the reduction of the excess beds, any facility which does not meet the guidelines and criteria shall not be issued a certificate of need.

Two amendments were adopted in Senate Committee on Health & Social Services. One requires that before any hospital closure is determined, consideration must be given to its impact on recruitment and retention of health professionals in the community. The other is designed to protect creditors and employes of hospitals which may be closed.

STATUS: Passed the House -- on the floor of the Senate with amendment.

HOUSE BILLS 4903, 4913, 4914 and 4917

SENATE BILL 576

LAETRILE THERAPY LEGISLATION

There are currently five bills before the Legislature with four in the House and one in the Senate. Rep. Kelsey has been the most vocal advocate of legalizing Laetrile therapy for cancer patients. In each piece of proposed legislation it is provided that Laetrile can only be obtained by prescription and that the physician is not liable if further deterioration in the condition of death occurs following the Laetrile therapy.

-- more --

Laetrile Therapy Legislation (cont'd)

STATUS:	All of these bills are still in House Committee on Public Health or Senate Committee on Health, Social Services and Retirement. A report favorable to Laetrile legalization has been introduced by a special committee on 3/22/78. As a result of this report, some action can be anticipated.
MSMS POSITION:	Oppose

HOUSE BILL 1527 1528 1529	SUPPLEMENTAL INSURANCE COVERAGE FOR FEDERAL HEALTH CARE RECIPIENTS
SPONSORED BY:	Senator Cooper
SUMMARY:	These bills would mandate insurance carriers to offer their insured a right of conversion to coverage which supplements their hospital, medical or surgical benefits when the subscriber becomes eligible for a federal program due to age or disability. These bills further outline that the forms of application, certificate, or other evidence of coverage and applicable rates, shall be filed with the insurance commissioner. Within 30 days after the filing, if the insurance commissioner finds that the rates charged to subscribers are excessive or discriminatory in relation to the benefits provided, he shall disapprove the subscriber rates.
STATUS:	Senate Commerce Committee
MSMS POSITION:	

HOUSE BILL 5546	REPORTING OF CRITICAL HEALTH PROBLEMS
SPONSORED BY:	Reps. Binsfeld, Hood, Kirksey, et al
SUMMARY:	The provisions of this bill outline that within 10 days of the diagnosis of a critical health problem the physician shall file a report with the Department of Public Health. This report shall contain information the Director of Public Health considers necessary to identify, locate, investigate the occurrence, frequency, incidence, cause, effect, and prognosis of the critical health problem.
STATUS:	Passed the House. Currently in Senate Health Social Services and Retirement.
MSMS POSITION:	

HOUSE BILL 5778	MEDICAL TREATMENT DECISIONS ACT
SPONSORED BY:	Rep. Hollister
SUMMARY:	This bill, commonly referred to as the Death and Dying Bill, legislates the individual's rights to refuse treatment in the event that he becomes terminally ill and/or incapacitated. It establishes a form by which an individual who has attained the age of majority, may appoint an agent to act in his behalf should he become incapable of making the decision to remove himself from life supporting machines. The bill specifically relieves the attending physician from any liability due to the consequences of being removed from this machinery.
STATUS:	House Committee on Public Health -- Public Hearings
MSMS POSITION:	Acceptable to organized medicine with one amendment.

HOUSE BILLS 5963, 5964, 5965, 5966, 5967 and 5968	CONFIDENTIALITY OF MEDICAL RECORDS
SPONSORED BY:	Rep. Brown, Hollister, Evans
SUMMARY:	These bills are designed to protect the confidentiality of an individual's medical records. Each bill is similar in content, however each addresses itself to different groups. The bills provide that the respective groups shall not disclose the medical records of an individual without the written informed consent of the individual.
STATUS:	Referred to various committees in the House.
MSMS POSITION:	Support

SENATE BILL 674	LOBBYIST DISCLOSURE ACT
SPONSORED BY:	Sens. Corbin, Hertel, and McCollough
SUMMARY:	The bill would require the registration and filing of reports by all lobbyists and their agents. The Senate Judiciary Committee defeated the original proposed bill by a vote of 4-3, based on the argument that the bill was too restrictive and would infringe upon the individual's and organization's right to petition their government.

-- more --

Lobbyist Disclosure Act (cont'd)

A substitute bill has been introduced and is currently undergoing extensive revisions. The new bill would still require reporting and registration of lobbyists and their agents, but it relaxes the financial thresholds of reporting to more reasonable levels. These thresholds are more realistically coordinated with the actual expenses incurred in lobbying.

STATUS: Reported out of Senate Judiciary Committee to full Senate.

MSMS POSITION: MSMS has joined a coalition of membership organizations who are involved in lobbying activity. The purpose of this coalition is to work for a reasonable approach to the registration and regulation of lobbying activities.

SENATE BILL 1391 PUBLIC HEALTH DEPARTMENT APPROPRIATIONS

SPONSOR: Sen. Toepp

SUMMARY:

Current Year Appropriations	$147,108,800
Proposed 1978-79	154,825,704
Local Health Services:	
Current Appropriations	$ 9,583,600
Proposed 1978-79	9,913,058

* * * * *

Laboratory Services:	
Current Appropriations	$ 2,217,900
Proposed 1978-79	3,176,561

* * * * *

Health Care Resources Development & Regulation:	
Current year appropriations	$ 18,085,700
Proposed 1978-79	17,125,902

This decrease is reflected due to a transfer of the Medicaid Surveillance unit from the Public Health Dept. to the Soc. Ser. Dept

* * * * *

Family Practice Residence Program:	
Current year appropriations	$ 1,000,000
Proposed 1978-79	1,000,000

Five of these slots are reserved for DOs
Each residency is not to exceed $5,000

* * * * *

Maternal and Child Health:	
Current year appropriations	$ 24,047,800
Proposed 1978-79	30,222,089

* * * * *

Michiga
Tax Lim

taxation, including property and local taxes, under voter control;
the proposed amendment appears on the reverse side of this

ich appears on the reverse side of this petition.

or said amendment to the Constitution.

hen not a qualified and registered elector,
iolating the provisions of the Michigan

POST OFFICE	DATE OF SIGNING		
	MONTH	DAY	YEAR

MAKE IT

Your signature on this petition
Michigan the opportunity to
government's ability to increa

Limit taxes to current % of tot
citizens.

Provides for tax refund if state
(see Sec. 26)

If state requires programs of lo
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A tax shift from state to local ta

Local government must get vo
any new taxes. (see Sec. 31)

INSTRUCTIONS FOR

1. You must check and list the
you are registered to vote.
2. Signers of each petition MUS
3. Married women MUST use t
Smith, not Mrs. John Smith
4. Signatures MUST BE made
culator. **Do not use zip cod**
5. Ditto marks MUST NOT BE u
to designate the month.
6. Circulator MUST BE A REG
7. Circulator SHALL NOT sig
prior to obtaining the last si
8. Circulator may sign a petitic
9. Partially filled petitions are l
turned in.
10. Return petition as soon afte

r date certificate until after circulating petition.

CIRCULATOR) (DATE)

WNSHIP WHERE REGISTERED)

TREET AND NUMBER OR RURAL ROUTE)

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Return petitions to

TAXPAYERS UNITED FOR
TAX LIMITATION.
24133 NORTHWESTERN H
SOUTHFIELD, MICHIGAN

Void if Duplicated. Write for

vice, and have certainly not

amendment, the state revenue and spending limits may be adjusted to accommodate such change, provided that the total revenue authorized for collection by both state and local governments does not exceed that amount which would have been authorized without such change.

Sec. 27. The revenue limit of Section 26 of this Article may be exceeded only if all of the following conditions are met: (1) The governor requests the legislature to declare an emergency; (2) the request is specific as to the nature of the emergency, the dollar amount of the emergency, and the method by which the emergency will be funded; and (3) the legislature thereafter declares an emergency in accordance with the specifics of the governor's request by a two-thirds vote of the members elected to and serving in each house. The emergency must be declared in accordance with this section prior to incurring any of the expenses which constitute the emergency request. The revenue limit may be exceeded only during the fiscal year for which the emergency is declared. In no event shall any part of the amount representing a refund under Section 26 of this Article be the subject of an emergency request.

Sec. 28. No expenses of state government shall be incurred in any fiscal year which exceed the sum of the revenue limit established in Sections 26 and 27 of this Article plus federal aid and any surplus from a previous fiscal year.

Sec. 29. The state is hereby prohibited from reducing the state financed proportion of the necessary costs of any existing activity or service required of units of Local Government by state law. A new activity or service or an increase in the level of any activity or service beyond that required by existing law shall not be required by the legislature or any state agency of units of Local Government, unless a state appropriation is made and disbursed to pay the unit of Local Government for any necessary increased costs. The provision of this section shall not apply to costs incurred pursuant to Article VI, Section 18.

Sec. 30. The proportion of total state spending paid to all units of Local Government, taken as a group, shall not be reduced below that proportion in effect in fiscal year 1978-79

n)

million)

A No. Tax credits such as these are specifically protected by this amendment.

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Proposed 1978-79 197,500,000 million)

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Article D
additions

Sec. 25.
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Sec. 26.
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the close of such fiscal year. If the excess is less than 1%, this excess may be transferred to the State Budget Stabilization Fund.

The revenue limitation established in this section shall not apply to taxes imposed for the payment of principal and interest on bonds, approved by the voters and authorized under Section 15 of this Article, and loans to school districts authorized under Section 16 of this Article.

If responsibility for funding a program or programs is transferred from one level of government to another, as a consequence of constitutional

Q What is Taxpayers United doing to bring about tax limitation in Michigan?

A Taxpayers United is staging a campaign to amend the Michigan Constitution, by obtaining 350,000 signatures of qualified voters to get the amendment on the November, 1978, ballot and then campaigning for its adoption.

Q Who is behind this drive for tax limitation?

A Retirees, housewives, farmers, factory workers, professionals, a broad spectrum of men and women. Many members of the Michigan Legislature endorse this campaign. Democrats, Republicans, and Independents support this effort.

Q Who is financing this campaign?

A Taxpayers United receives contributions from all walks of life, from just a few dollars to many hundreds of dollars. We are seeking 100,000 concerned taxpayers to contribute a minimum of $5 each. You can help! Send a check to **Taxpayers United For Tax Limitation.**

Q What can I do to help?

A Get involved, by signing or helping to circulate petitions in your neighborhood. Sign the tax limitation petition even if you already have signed other petitions associated with the November, 1978, election. Become familiar with the issues involved and let your friends and neighbors know what's really at stake: their right to have a strong voice in the setting of tax rates in Michigan. Above all, in November, vote YES to the tax limitation proposal.

Paid for by:
Taxpayers United For Tax Limitation
P.O. Box 5060
Southfield, MI 48037
Phone (313) 358-1978

Co-Chairpersons:
Jeffrey M. Leib, Thomas H. Ritter,
Mrs. Vickie St. Louis, Jay VanAndel;
Treasurer: James Barrett.

Sponsored by:
Taxpayers United, Inc.
Richard H. Headlee, Chairman
William Hanson, Executive Director

MICHIGAN
NEEDS
A
LIMIT
ON
TAXES
MAKE
IT
HAPPEN

SENATE BILL 1432
1433
HOUSE BILL 6021

HIGHER EDUCATION APPROPRIATIONS
(Section on Medical Schools)

SPONSORS: Sen. Huffman
Rep. Jacobetti

SUMMARY:

Wayne State University Medical School:

Current Year Appropriation	$ 16,927,894
Proposed 1978-79 appropriation	18,840,746

WSU Medical School has proposed the establishment of a Department of Radiation Therapy -- this is not included as a line item increase.

* * * *

Michigan State University College of Human Medicine:

Current Year Appropriation	$ 6,906,805
Proposed 1978-79 appropriation	7,687,330

* * * *

Michigan State University School of Osteopathy:

Current Year Appropriation	$ 4,969,513
Proposed 1978-79 appropriation	5,531,068

* * * *

University of Michigan Medical School:

Current Year Appropriation	$ 15,329,186
Proposed 1978-79 appropriation	17,061,384

None of the state university medical schools are anticipating increasing its enrollment in 1978-79 freshman classes. The above increases represent 6% increase for inflation and 5% increase for improvement, i.e., updating existing program, and facilities and improving faculty-student ratios.

Each school has made an additional request for the continuation of their clinical centers.

WSU	$ 1,000,000
U of M	$ 920,000
MSU (both)	$ 1,000,000

HOUSE BILL 6049

DEPARTMENT OF SOCIAL SERVICES BUDGET APPROPRIATIONS
Medicaid Appropriation (Segment of Dept. of S. S. Budget)

Current Year Appropriation	$908,720,910	(Est. lapse, $113.6million)
Proposed 1978-79 appropriation	$916,800,000	

* * * * *

Physician services line item:

Current Appropriation	$146,100,000	(Est. lapse, $33.3 million)
Proposed 1978-79	$135,100,000	

* * * * *

Nursing Home line item:

Current Appropriation	$193,355,200	(Est. lapse, $14.2 million)
Proposed 1978-79	197,300,000	

* * * * *

SENATE BILLS		PRIMARY SPONSOR	SUBJECT	STATUS
SB 124	(*)	Toepp	1-year Hospital Arbitration Agreement	Sen. Jud.
SB 139		Davis	Transportation of Radio-Active Materials	Sen. State Affairs
SB 193		Plawecki	Blood Banks	Sen. Health, S.S. & Retirement
SB 297		Toepp	Liab. for tortious acts for employees of state facilities	Sen. Judiciary
SB 337		Kammer	Regulate over/counter Sedatives	Senate Appropriations
SB 347	(-)	Hertel	Notification/Dangers: Ionizing Radiation	Sen. Health S.S. & Retirement
SB 477		Guastello	Earmarking Funds; Medical Practice Board	Sen. State Affairs
SB 576	(-)	Welborn	Laetrile Therapy	Sen. Health S.S. & Retirement
SB 613		Allen	Prophylactic Display	Sen. Health S.S. & Retirement
SB 674		Corbin	Lobbyists Disclosure	Sen. floor with substitute
SB 683	(-)	Geake	Fifth Pathway Program	Sen. Appro.
SB 734		McCollough	Single Business Tax Reduces Rates	Signed, P.A. No. 273
SB 821		Otterbacher	HMO Advisory Commission	Sen. Health S.S. & Retirement
SB 822		Otterbacher	HMO Licensure	Sen. Health S. S. & Retirement
SB 823		Otterbacher	Prohibits Discrimination Against HMO's	Sen. Health S. S. & Retirement
SB 829		Welborn	Ban Abortions under Medicaid	Sen. Health S.S. & Retirement
SB 867		Bishop	Canadian Physicians obtain Michigan license	Sen. State Affairs
SB 912		Hertel	Hospitals sep. surg. fac. required for OB patients	Sen. Health S.S. & Retirement
SB 924		Otterbacher	Single Business Tax	Sen. Finance
SB 925		Otterbacher	Single Business Tax	Sen. Finance
SB 926		Otterbacher	Single Business Tax	Sen. Finance
SB 1035		Huffman	Divides State into 78 Health Facilities Service Areas	Sen. Health S.S. & Retirement
SB 1038		Otterbacher	Single Business Tax	Sen. Finance

HOUSE BILLS	PRIMARY SPONSOR	SUBJECT	STATUS
HB 4028 (*)	Defebaugh	Liab. for tortious acts for employees of state facilities	House Judiciary
HB 4070 (*)	Hood	PHSRP	Senate Appropriations
HB 4110 (-)	Geake	Fifth Pathway Fund	House Approp.
HB 4135 (*)	Padden	One-Day Trial Duty	Signed, P.A. 11
HB 4215	Bryant	Limit of Malpractice Awards	House Judiciary
HB 4263	Nash	Litigation Fees	House Judiciary
HB 4420 (-)	Geerlings	Dentists/Death Certificate	House on State Affairs
HB 4425 (*)	Collins	Sex Ed. in Schools	Signed, P.A. No. 226
HB 4439	Symons	Definition of Death	Senate Judiciary
HB 4491	Kehres	Reduction of Hospital Beds	Senate Floor With Amendments
HB 4515 (*)	Stevens	Definition of Malpractice	Signed, P.A. No. 272
HB 4902 (*)	McNeely	Exten. of Brown-McNeely Fund	Signed, P.A. No. 42
HB 4903 (-)	Kelsey	Laetrile Therapy	House Pub. Health
HB 4913 (-) 4914, 4917	Trim	Laetrile Therapy	House Pub. Health
HB 4918	Angel	Arbitration of Malpractice	House Judiciary
HB 4920	Angel	Prevents Disclosure of Liability Coverage	House Committee on Ins.
HB 4936 (*)	R. Hood	Three-Year CME Requirements	Signed, P.A. No. 123
HB 5433	Symons	Exclusive Remedy & Comp. for Malpractice	House Committee on Ins.
HB 5450	Bullard	BC/BSM Election Procedure	House Committee on Ins.
HB 5477	Law	Determination of Licensure in Another State	House on State Affairs
HB 5578	McCollough	Eyes-Permits removal under Certain Circumstances	House Public Health
HB 5747	Ryan	Interim Approval for PAs	Signed, P.A. No. 297
HB 5778 (*)	Hollister	Death & Dying Definition	House Public Health

MSMS POSITION (*) Support (-) Oppose

THE HOUSE REQUESTED THE MSMS COUNCIL to recognize physicians' concerns about Health Maintenance Organizations as a high priority activity and to continue to monitor the enrollment, subsidization and cost effectiveness of the entire HMO program and to share information with MSMS members.

THE HOUSE CALLED FOR REVIEW of the reasons why high-risk physicians applying for insurance with the Michigan Physicians Mutual Liability Insurance Company are so classified.

THE HOUSE CALLED FOR THE DUES now paid by medical students, interns and residents for membership in the American Medical Student Association and the AMA to be applied toward the regular AMA membership fee when those physicians apply.

THE HOUSE RESOLVED THAT MSMS INTENSIFY and identify its concern with health planning through establishment of a steering group of physicians charged to closely monitor and advise the Statewide Health Coordinating Council; assist in all possible ways members who serve on health systems agencies (HSAs); continue the flow of information on health planning to physicians representatives via a newsletter; communicate with the "consumer" members of planning boards; and work to establish a consortium of the voluntary health agencies so their views can be heard in health planning.

THE HOUSE CALLED FOR MSMS to assess in three years the effect of the new rules established by the Medical Practice Board on the prescription and distribution of amphetamines, and for MSMS to be allowed to comment on impending rules and regulation of the Medical Practice Board in the future.

THE HOUSE REQUESTED COMPONENT MEDICAL SOCIETIES to investigate laboratory ownership arrangements within their boundaries and take immediate action to assure their physician members are not associated with any lab ownership schemes which exploit the patient.

THE HOUSE RESOLVED THAT MSMS seek legislation to immediately correct the inequity of the Department of Licensing and Regulation's deriving investigatory fees from a tax upon physicians as such a tax is not applied equally to all licensing boards. MSMS is to seek legislative repeal of the law which allows for this discriminatory tax.

THE HOUSE CALLED ON THE COUNCIL to establish a committee to develop MSMS policy on physicians' assistants and to forward this policy to the Medical Practice Board.

Ways and Means

THE HOUSE APPROVED THE WAYS AND MEANS Committee's report approving the addition to MSMS headquarters, and the report which finds the MSMS fiscal condition sound.

THE HOUSE APPROVED REPORTS of the House Ways and Means studies to analyze the effectiveness and validity of current MSMS fiscal policies, which led to changes in MSMS investment counselors and appointment of an additional investment monitoring firm to review the MSMS investment counselors.

THE HOUSE APPROVED THE WAYS AND MEANS Committee's report that its study of MSMS capital and creative reserve funds shows those funds to be valid and needed.

Constitution and Bylaws

THE HOUSE APPROVED ON FINAL reading that seniority of alternate delegates to the AMA be decided by the length of service of each alternate.

THE HOUSE APPROVED ON FINAL reading establishment of MSMS sections on resident physicians and emergency medicine.

THE HOUSE APPROVED ON FIRST READING amended duties of the secretary and revised the provision re expulsion of MSMS members whose licenses are revoked.

THE HOUSE APPROVED ON FIRST READING a change in the way medical specialty delegates are chosen for the MSMS House of Delegates. If given final approval next year, specialty societies will each have one delegate. At present delegates are chosen by MSMS Sections.

MSMS officers/continued

Secretary Kenneth H. Johnson, MD, Lansing, who has chosen to serve as assistant secretary. John R. Ylvisaker, MD, Pontiac, and Leland E. Holly, II, MD, Muskegon, were re-elected treasurer and assistant treasurer.

In other elections, four incumbent delegates to the AMA whose terms had expired were re-elected. They are Brooker L. Masters, MD, Baldwin; Richard J. McMurray, MD, Flint; Robert E. Rice, MD, Greenville; and Frank B. Walker, MD, Grosse Pte. Farms.

Four alternate delegates to the AMA who also were re-elected are George M. Wilson, MD, Marquette; Robert D. Burton, MD, Grand Rapids; Richard H. Gascoigne, MD, Adrian; and Robert D. Allaben, MD, Detroit.

Incumbent MSMS Councilors whose terms had expired were re-elected. They are Louis R. Zako, MD, Dearborn Heights, 1st District; James H. Tisdel, MD, Port Huron, 7th District; Robert J. Toteff, MD, Saginaw, 8th District; Charles L. Oppy, MD, Roscommon, 10th District; Busharat Ahmad, MD, Marquette, 12th District and Frederick W. Bryant, MD, Royal Oak, 15th District. Richard L. Rapport, MD, Flint, was elected to fill the remainder of Doctor Griffin's term (6th District).

Michigan MDs honored by MSMS

A number of Michigan physicians received honors and awards at the 1978 House of Delegates meeting.

Maurice S. Reizen, MD, director, Michigan Department of Public Health, received a special Presidential Citation in recognition of his exemplary leadership of the MDPH since 1970.

Receiving National Presidents Awards for service as president of a national organization were: S. J. Behrman, MD, American Fertility Society; Bruce L. Danto, MD, American Association of Suicidology; Bernard M. Schuman, MD, American Society for Gastrointestinal Endoscopy; and Robert J. Priest, MD, Bockus International Society of Gastroenterology.

MSMS Flag Awards were presented to Royal C. Hayden, MD, president, Michigan Association for Better Hearing and Speech; Arthur H. Ulmer, MD, president, American Cancer Society, Michigan Division, Inc.; and Vernon E. Wendt, MD, president, Michigan Lung Association. MSMS Past President Vernon V. Bass, MD, received a Certificate of Appreciation for his 10 years' service to the Michigan AMA delegation.

Doctor Coury writes AMA article

The first article in a special American Medical News series entitled "Malpractice Update" is by John J. Coury, MD, MSMS past president and member now of the AMA Board of Trustees. Doctor Coury, AMA representative on the American Bar Association's Commission on Medical Professional Liability, writes in the April 28 issue of AM News, "I challenge the medical profession to rid itself of its incompetent physicians, to improve our continuing medical education programs and to enchance doctor-patient relationships."

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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Managing Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine Medigram

VOL. 77, NO. 15 MAY 26, 1978

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Physicians/Blues work group digging in on new agreement

A new eight-man work group is beginning efforts to achieve the objectives of the agreement just ratified by MSMS and Blue Cross/Blue Shield of Michigan. The agreement, adopted by the MSMS House of Delegates May 7 and by the Blues' board on May 11, establishes four basic principles for a better health care system. These are (1) implementation soon of an effective health care cost control program, (2) an effective service benefit program, (3) reimbursement policies supportive of service benefit and cost containment principles, and (4) equal treatment of all physicians within a reimbursement system consistent with the first three principles.

On the work team for the Blues are: BCBSM board members Ellsworth Reynolds, president, American Natural Service Co., and Robert Walker, coordinator, Benefit Plans Section, General Motors Dept., UAW; BCBSM corporate body member Frank Blackford, vice president, College Planning and Development, Macomb County Community College; and Walter Maher, Director of Wage Benefits for Chrysler Corp. The work team for physicians includes John B. Bryan, MD, Royal Oak, chairman, MSMS Committee on Claims Forms and Michigan Uniform Code; Donald K. Crandall, MD, Muskegon, chairman, MSMS Committee on Negotiations; and a third to be named.

Blues seek physician input for UAW-auto contract talks

As this Medigram was going to press, the Blues were contacting MSMS to ask for physician input on new benefit programs to be negotiated during the next UAW-auto company contract talks. This meets a long-expressed desire of Michigan physicians. Louis E. Heideman, MD, MSMS president, has been appointed head of MSMS efforts to provide physician information, with Richard Campau, MSMS staff coordinator.

APSULES

egistrations still can be
ade for MSMS Practice Manage-
ent workshops scheduled June
in Detroit, June 8 in Lan-
ing and June 9 in Traverse
ity. Registrations for the
une 7 workshop in Southfield
re filled. "Financial Con-
rol of Your Medical Practice"
s the theme of the seminars.
urther information is avail-
ble from John Richards at
SMS headquarters.

* * *

unique workshop for 30 Mich-
gan physicians and their
pouses is planned June 16-18
y Michigan Psychiatric Soci-
ty and members of two MSMS
ommittees. The workshop is
o help improve medical
arriages, and teach the
ouples involved to help
ther physicians and spouses.
ighteen hours of Category I
ME credit will be awarded.
egistrations must be made by
une 7. Location of the work-
hop will be the Meadowbrook
all mansion, Rochester, on
he Oakland University campus.
urther information is avail-
ble from the Michigan
sychiatric Society, Box 950,
ast Lansing, 48823.

* * *

ew MSMS President Louis E.
eideman, MD, calls for Mich-
gan physicians to spend time
ach day talking with patients
o help them gain a more bal-
nced view of medical issues.
is appeal is on page 314 of
e May issue of Michigan
edicine, and is part of
octor Heideman's first
resident's page" message.

* * *

ernon V. Bass, MD, Saginaw,
as re-elected president of
e Michigan Physicians
utual Liability Company at

(Cont. back page)

CAPSULES/continued

the MPMLC annual meeting recently. Robert M. Leitch, MD, Battle Creek, already a board member, was elected first vice president to succeed Frank B. Walker, II, MD, who resigned from the board. Ernest P. Griffin, Jr., MD, Flint, was re-elected secretary-treasurer, and Dean R. Olson, DO, Lansing, was elected to fill the unexpired board membership of Doctor Walker.

* * *

The Michigan Department of Public Health asks Michigan physicians to assist in determining if there is evidence of any adverse health effect from current total ingestion of fluorides. Any symptoms of fluorosis should be reported to Maurice S. Reizen, MD, Director, MDPH, 3500 N. Logan St., Lansing, 48909. A more detailed explanation will appear in the June issue of Michigan Medicine.

* * *

Louis E. Heideman, MD, MSMS president, will represent MSMS at the 59th annual meeting June 28-30 of the Michigan Hospital Association. The convention is scheduled for the Grand Hotel, Mackinac Island.

Ingham MDs piloting charge card payment plan

A pilot study using a charge card system for payment of physicians' bills is being started by MSMS and Michigan Bankard with members of the Ingham County Medical Society. If the system is satisfactory to both the charge card company and the Ingham MDs at the end of the 90-day trial period, MSMS plans to enter into an agreement for all members. The agreement would enable MSMS members to receive a significant reduction in the discount rate they have to pay for use of the charge card system.

The MSMS Council on March 8 directed staff to explore the possibilities of a credit card approach to collecting physicians' fees. Dollar volumes, average amounts, use per member and delinquencies will be carefully tracked during the pilot study. While the study progresses, other Michigan physicians may continue to use credit card payments at regular rates.

Planners study suggestions to alter current fee system

At its May 18 meeting the Statewide Health Coordinating Council (SHCC) reviewed a large number of suggested objectives for the State Health Plan -- including a rate-setting mechanism for physicians' fees; expansion of utilization review mechanism to include consumers, other health professionals and physicians from outside the region; mandatory second consultations; elimination of separate reimbursement on a fee-for-service basis for hospital radiologists and pathologists; capital expenditure caps; and mandated additions to health insurance benefits.

The suggested objectives are mere "suggestions" right now, but they represent the type of thinking that is going on within SHCC. MSMS representatives are preparing to critique the objectives and will seek the help of specialty groups and the hospital association. Consideration of these and other objectives is scheduled for July 20-21.

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Vol. 77 No. 15, May 26, 1978

MEDICAL COSTS

Michigan Medicine

JUNE 1978 • VOLUME 77, NUMBER SIXTEEN
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MSMS GOALS:

To INCREASE PHYSICIAN AWARENESS OF MEDICAL COSTS.

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CAPSULES/cor

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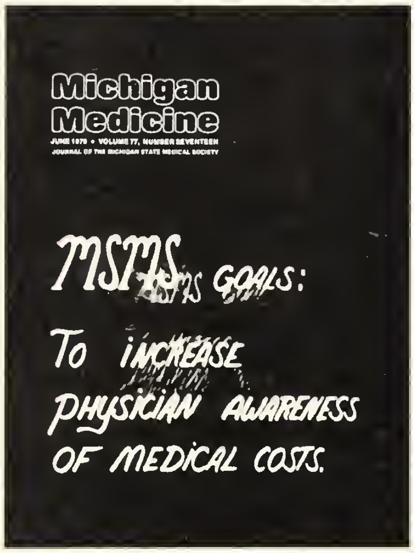
Contents

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.


Michigan Medicine
JUNE 1978 • VOLUME 77, NUMBER SEVENTEEN
JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY
MSMS's GOALS:
To INCREASE
PHYSICIAN AWARENESS
OF MEDICAL COSTS.

BILL MITCHAM

MSMS is deeply involved in the battle to hold down the rise in health care costs by helping its members know more. Please see special section pages 315-318 for further discussion.

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MSMS working on many fronts to combat rising health care costs

By Richard M. Campau, Manager MSMS Department of Health Care Delivery

There are probably no topics more widely discussed today than the high cost of living in general, and the high cost of medical care in particular — if we are to believe our federal bureaucrats, the nation's news media and worried hospital and medical leaders.

There is no question ever-burgeoning costs of delivering medical care to a growing and more demanding population are gaining critical looks from every corner.

Medicine is attempting to answer the critics and find solutions.

The pressures

There is the bureaucratic/legislative hue and cry for national health insurance as the answer to all health care problems. Pressures to control medical costs (and medicine) are coming from the federal level in the form of congressional bills aimed at somehow "getting a handle" on the matter.

On federal and state levels, we are seeing increasing pressures from third party payors aiming to get some control over the payouts they are making.

This emphasis on controlling costs has provided a strong impetus on federal, state and local levels for development of alternative methods of providing health care. One of the most notable of these is the continued effort to establish Health Maintenance Organizations. Neither the AMA nor MSMS has any real quarrel with the HMO concept if HMOs can be established in a true competitive, free enterprise fashion.

On yet another front, we know federal and state planners are looking carefully at certificate of need legislation for possible extension to the physician's office.

Last fall at a conference attended by physicians, nurses and others interested in health care, the audience heard Mel Glasser, director of social security benefits for the United Auto Workers International, call for an end to the fee-for-service system in favor of a system which would simply place all physicians on a salary.

On the state level we are faced with a bill which places caps on hospital charges and controls bed utilization. The massive PHSRP bill moving slowly through the legislature also contains a number of segments addressed to controls of medical care costs.

Enough of the ominous noises heard around us. What is being done to address the problem and find solutions short of resigning ourselves to a complete federal takeover of the entire health care system?

National Commission

On the national level, the AMA and the AHA long have advocated a voluntary approach, with hospitals, physicians, consumers, insurers and the like working together to bring about cost-effective methods of providing health care. In 1976 the AMA and AHA organized the National Commission on the Cost of Medical Care as an independent body to examine the entire field of health care and offer realistic recommendations. That Commission issued its Summary Report in December at the AMA winter House of Delegates meeting. The report was received for study and is to be comprehensively addressed and debated at this summer's AMA House meeting in St. Louis. The report's 48 recommendations for restraining medical care costs are directed at the medical profession, consumers, the health insurance industry, and the government. Among the recommendations directed at the medical profession are:

— Physicians, hospitals, insurers, and others should work at the local level to agree on reasonable levels of reimbursement.

— The medical profession should develop and disseminate guidelines for appropriate care based on criteria of medical necessity, quality and cost benefit. Neither the patient nor third party payor should bear the costs of decisions which result in inappropriate care.

— Physicians should make available, in a regional directory, such information as prices for rather well-defined procedures, length of time required to obtain an appointment, willingness to accept new patients, institutional affiliation, and whether they are board-certified.

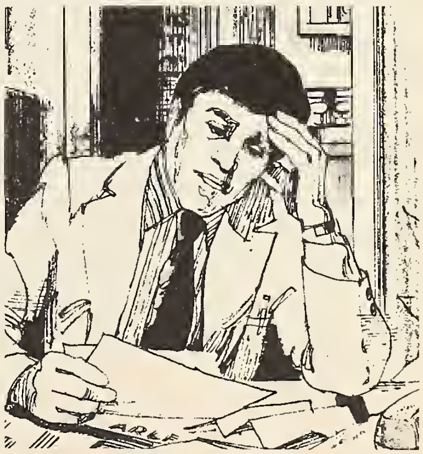
— A major research effort, concentrating upon patient outcomes or upon process measures should be taken so the quality of care given by a provider can be measured.

MSMS concerns, actions

What are our own MSMS concerns and actions to develop an effective cost control program on the state level which has feasible possibilities for application on the local hospital level?

At the May, 1977 House of Delegates Meeting, the delegates adopted a resolution calling for establishment of a Task Force on Medical Care Costs. That Task Force was duly appointed and has been meeting. The task force has examined the National Commission's report and already has taken steps to include some of these recommendations in its thinking and program development.

(Continued on page 318)



MSMS task force chairman believes hospitals, physicians must do much about costs

By Elizabeth Cummins
***Special to* Michigan Medicine**

Can some of the waste in the health care delivery system be eliminated? Definitely, says Frederick VanDuyne, MD, a Flint family physician.

Doctor VanDuyne chairs the MSMS Task Force on Medical Care Costs. The task force is setting guidelines for doctors to use in helping their communities and hospitals deal with the cost of health care.

The task force is not dealing with broad, philosophical issues, Doctor VanDuyne reports, but is looking at immediate steps that can be taken.

Doctor VanDuyne says the task force will draw upon research of the National Commission on Health Care Costs. Doctor VanDuyne says the research has been divided for study by members of the task force, and that it appears to be a fine document.

MDs must support

Some of the recommendations the task force will make, such as increased outpatient surgery, preadmission testing and improved discharge planning, are not new. But they aren't being implemented as widely as they could be, Doctor VanDuyne says.

"These are the kinds of things a doctor has to get behind," he says. "He has to go to his hospitals, to his people who are delivering health care, and say, 'We want to get into outpatient surgery. Here is how you go about it and here is what you need.' "

Doctor VanDuyne believes most doctors do not know the cost of the tests they order, a situation that the task force will seek to change. If doctors become aware of the costs of tests, they will order them more cautiously, he says. Doctor VanDuyne thinks there are several ways to accomplish this.

One is to publish periodically a list of prices of everything from a simple blood test to the most exotic diagnostic study.

Another is to periodically send doctors itemized copies of the patient's bills. This would not have to be done with every patient, he says.

"In areas where this has been done, it has had an impact," he says.

He believes pre-admission testing is an underused device that could help contain costs. It is being done in some hospitals, while others are not considering it, he says.

"This would mean to start doing tests before the patient goes into the hospital and coordinate those tests so they are on the patient's chart before he arrives at the hospital.

"And as soon as he does arrive, planning for discharge should be started. This planning would involve doctors, nurses, administrators and the social work departments," he says.

As president of the Genesee Medical Corp., which set up the Professional Standards Review Organization (PSRO) for Genesee, Lapeer, Shiawassee counties, Doctor VanDuyne is familiar with lengths of stay.

Between 60 and 90 patients per month linger needlessly in the hospitals of those three counties because they have no place to go. Those patients stay an average of 10 extra days each, which means at least 600 patient days per month are wasted.

"You cannot discharge those people into the parking lot. The answer lies in new facilities or in a new form of reimbursement. There is no real short-term solution and you can't create one overnight," he says.

Doctor VanDuyne also believes money could be saved by better utilizing space within the hospital, setting aside areas for generally-healthy patients who undergo surgery and don't need close supervision in latter days of recuperation.

"One of the problems doctors have is that all through medical training the idea of cost never is mentioned. What is mentioned is the best thing for the patient."

Cost-containment difficult

Combined forces of medical training and the need to practice defensive medicine, which stress the best for the patient and ignore cost, make cost-containment a wrenching experience for a new physician, Doctor VanDuyne says.

But he believes that to contain costs, some of the testing may have to be eliminated. If so, the public will have to understand why and stand behind the doctor's decisions.

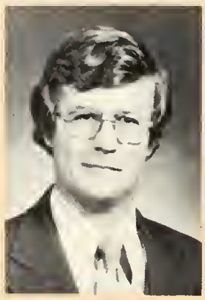
Doctor VanDuyne is medical director of the Health Maintenance Organization (HMO) being organized in Flint.

He believes the HMO concept is the mechanism for dealing with underusers and overusers who then will be controlled by their fellow patients.

Despite all creative efforts, Doctor VanDuyne believes medical costs will continue to rise disproportionately to other consumer goods.

"We can slow the rise and eliminate the waste, but a rise is inevitable, unless you make a management decision not to participate in technological advances and offer them to an increasing portion of the population.

"But still there are things a physician can do and ought to be actively trying to institute in the hospitals."



Doctor VanDuyne

Here are first guides on cost awareness from MSMS task force

Practical Guide #1: Diagnostic Testing

Description:

When physicians consider the cost of health care, they should be aware of the cost to the patient of the services ordered. This cost awareness program will alert physicians to the cost of laboratory, x-ray, and EKG tests, with ultimate patient costs savings.

Objectives:

The objectives of the diagnostic test cost awareness program are:

A. To encourage physicians to re-evaluate their testing routine, and tests required by hospital policies and procedures.

B. To alert physicians to the cost of common testing procedures.

C. To alert physicians to the importance of stop orders where indicated.

Methodology:

A. The medical staff and the hospital administration should review and evaluate hospital policies and procedures covering mandatory admission testing, and recommend revisions where appropriate. Evaluation should cover such concerns as:

1. Are all of the required procedures necessary in all admissions?

2. Would selective testing ordered by the physician be more appropriate, both in cost and medical benefit to the patient?

3. Is provision made for avoiding duplication of tests?

B. Individual physicians should annually re-examine their own standing orders for hospital admission to determine if they also meet the criteria in "A".

C. Hospitals should keep their medical staffs informed of the patient billing charges for laboratory, x-ray, and EKG testing procedures. Methods of doing this could include:

1. Posting the charges for the 15 most common test procedures. The information could be posted in doctors' lounges, nursing stations, and other appropriate locations.

2. Informing physicians of the cost of their patients' hospitalizations.

D. Physicians should re-examine medical staff policies regarding stop orders to avoid unnecessary testing.

Practical Guide #2: Pre-Admission Testing

Description:

Pre-admission testing (PAT) is a program administering tests on an outpatient basis prior to a scheduled hospital admission. Pre-admission tests include laboratory tests, x-rays, and electrocardiograms. Experience has shown that, properly designed and implemented, PAT programs can result in significant savings. The amount of savings is highly dependent upon the extent of the PAT program undertaken by the individual hospital. PAT programs have been most successful when applied to overall hospital operations, rather than to only Friday admissions, specific diagnoses, or other limited applications.

Objectives:

The objectives of PAT programs are:

A. To reduce total cost of hospital stay by shortening the average length of stay.

B. To assure that test results are available before performing surgery or beginning other treatment.

Methodology:

A. The hospital should survey physician attitudes concerning the admission process and use the comments to develop a PAT program.

B. Both the medical staff and hospital administration should develop policies and procedures concerning PAT, including such things as:

1. *Specific Durations of Time the Test Results will be Valid.* This will specify the number of days before admission that PAT tests can be done.

2. *Physician Standing Orders.* The medical staff should review the current policy on standing orders and the individual tests included in the admission package. (A routine battery of tests unrelated to a patient's condition is not reimbursable by most third party payors.) Standing orders that are based on diagnosis, age, or procedure are recommended.

3. *Physician Special Orders.* Procedures should be developed for the hospital to obtain orders specific to individual patients. This could be accomplished by several methods, including the doctor delivering the orders to the hospital, mailing or telephoning them, or sending the orders with the patient.

4. *Availability of Test Results.* The test results must be available before admission so the physician can cancel or postpone the admission if necessary.

C. PAT patients should be identified by the physician when scheduling admission, taking into consideration medical or geographic contraindications. Physicians should explain to their patients what is going to happen, and emphasize the advantages of PAT.

(Continued on next page)

Frederick VanDuyne, MD, chairman of the MSMS Task Force reported to the 1978 House on the progress of the committee. He also shared with the House the first two practical guides developed by his Task Force. (See accompanying report.)

The Task Force sees itself in two lights. First, it has an obligation to address the larger picture of health care costs. Much of its long-range planning will evolve out of AMA actions this summer. Meanwhile, the MSMS task force has addressed itself to some immediate, short-range cost awareness goals of soundness and practicality. The task force determined its first priority would be to develop a series of practical guides for implementing physician cost containment initiatives at the local hospital level. The focus of these guides will be on (a) alerting hospital medical staffs to the costs of diagnostic testing, (b) pre-admission testing for elective admissions, (c) curtailing Friday and Saturday admissions, (d) discharge planning, (e) greater use of outpatient surgery, (f) cost-effective utilization of hospital emergency rooms, (g) cost-effective use of nonphysician manpower and (h) cost-effective non-acute care.

Also, component medical societies will be asked to assign work groups to monitor implementation of the practical guides by local hospital staffs and to develop their own cost containment initiatives to share with other county societies via the state task force.

Educational programs

The Task Force also is working with the MSMS Committee on CME Programming and the Michigan Medical Schools Council of Deans to develop educational programs for physicians and medical students. The Committee hopes to influence medical school faculties and CME programs to include cost awareness and cost effectiveness as part of medical education.

Joint efforts with Michigan Hospital Association

The Michigan Hospital Association also has appointed a Committee on Cost Containment in keeping with the efforts of "Voluntary Effort," the organization begun by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals. Representatives from the MHA committee have met with the MSMS Task Force. The MHA committee is working on programs to make hospital operations more efficient. The MSMS Task Force is sending representatives to meetings of the MHA committee.

Michigan Department of Social Services

In 1976, the Michigan Department of Social Services designed a program to save Medicaid expenditures of approximately $30 million for fiscal year 1976-77. Key cost saving elements of the plan included (1) preadmission testing, (2) pre-payment review for patients staying beyond the 75th percentile length of stay, and (3) an expanded surveillance and utilization review system with provider peer review to identify patient and provider abuse and overutilization. The Task Force is working with the MSMS Medicaid Liaison Committee to determine the success of the program and explore its applicability to the private sector.

And these are the initial thrusts of the committee's activity. Doctor VanDuyne and his task force members are committed to continuing their study and search for effective measures to contain and control rising medical costs.

This report is by no means exhaustive in its depth or detail and is not intended to be. There are literally hundreds of areas which inter-relate and have bearing on the total cost problem. The MSMS Task Force has been meeting several hours monthly as have been its subcommittees in an effort to develop even these basic guideline drafts. Its intent is to produce some early, effective steps which physicians can implement to deal with costs.

The Task Force is fully cognizant of the fact that many aspects of rising medical costs are beyond the physicians' direct control. Yet, it is physicians and hospitals who are bearing the brunt of the criticisms about health care costs. Therefore, it behooves our Task Force to develop visible efforts which will have public impact in demonstrating physician concern with cost containment. The Task Force is not forgetting the long-range view, either.

You will continue to hear about the work of the Task Force via *Medigram* and *Michigan Medicine*. MSMS is committed to a comprehensive review of the entire problem. We are likewise committed to developing possible solutions and sharing our thoughts and findings with physicians and the public alike. As Doctor Jim Sammons said recently in a letter to medical chiefs of staff in explaining the AMA's position, "The medical profession's concern for the patient makes it our responsibility to seek the maximum efficiency and economy in health care delivery which can be achieved without detriment to the quality of that care." MSMS leaders share that sentiment and are willing to commit our resources to accomplishing that goal insofar as doctors can directly influence some portions of the medical cost picture.

PRACTICAL GUIDES/*continued*

D. At the time the admission is scheduled, tests should also be ordered by the physician. It is important that all necessary tests are performed at the same time on an outpatient basis. Otherwise, inpatient days are taken up with additional testing and the benefits achieved through PAT are lost.

E. The hospital should notify the physician of any abnormal test results as soon as possible. This will allow time to cancel an admission, if necessary, and reschedule another patient.

AMSA-MECO project introducing 32 Michigan med students to community practice

By Maryanne Butt
Special to **Michigan Medicine**

Thirty-two Michigan medical school students will experience community medical practice first-hand this summer with MSMS help. They have been assigned to 19 participating community hospitals in the state.

This valuable educational opportunity is made possible through the AMSA-MECO program (American Medical Student Association — Medical Education in Community Orientation program), and the Michigan State Medical Society.

AMSA-MECO, in its eighth year in Michigan, is a nationally coordinated network of educational programs for medical students which has been consistently successful.

Students are assigned to individual physicians who serve as their teachers and counselors. MECO is designed to expose these students to the community practice of medicine as a supplement and alternative to the disease-oriented and highly specialized medicine taught in medical schools. The students are able to observe the interrelationships between patients, physicians, nurses, social workers, psychologists and all persons involved in the health care system.

MECO's goals

MECO's long-range goals are 1) to affect the future distribution of health manpower in the United States, 2) to affect future patterns of health care delivery, and 3) to provide an opportunity for health science students to participate in the development of their own educational program, as a means of establishing a true continuum of education extending beyond the medical school year.

A high percentage of medical students return to practice in the area of their program or nearby, thus positively affecting distribution of physician manpower in the state.

Pre-clinical medical students (primarily pre-sophomores) who are members of AMSA are eligible for the program. The students each are based in a community hospital, clinic, or with a private physician for the summer extramural program.

It is the responsibility of the student participant and the physician director to jointly design a program which reflects particular needs of the individual student and community, while fulfilling the MECO objectives.

MECO's outlined objectives are:

1) To introduce the student to the community and to the cultural, economic, political and environmental determinants of health in that community;

2) To introduce the student to the organization and operation of health care institutions as related to delivery of health care in the community;

3) To enable students to evaluate their career goals and better plan their medical education as related to specific community needs in health care;

4) To provide community exposure to future health care personnel;

5) To enable the student to understand the basic concept of patient-oriented health care;

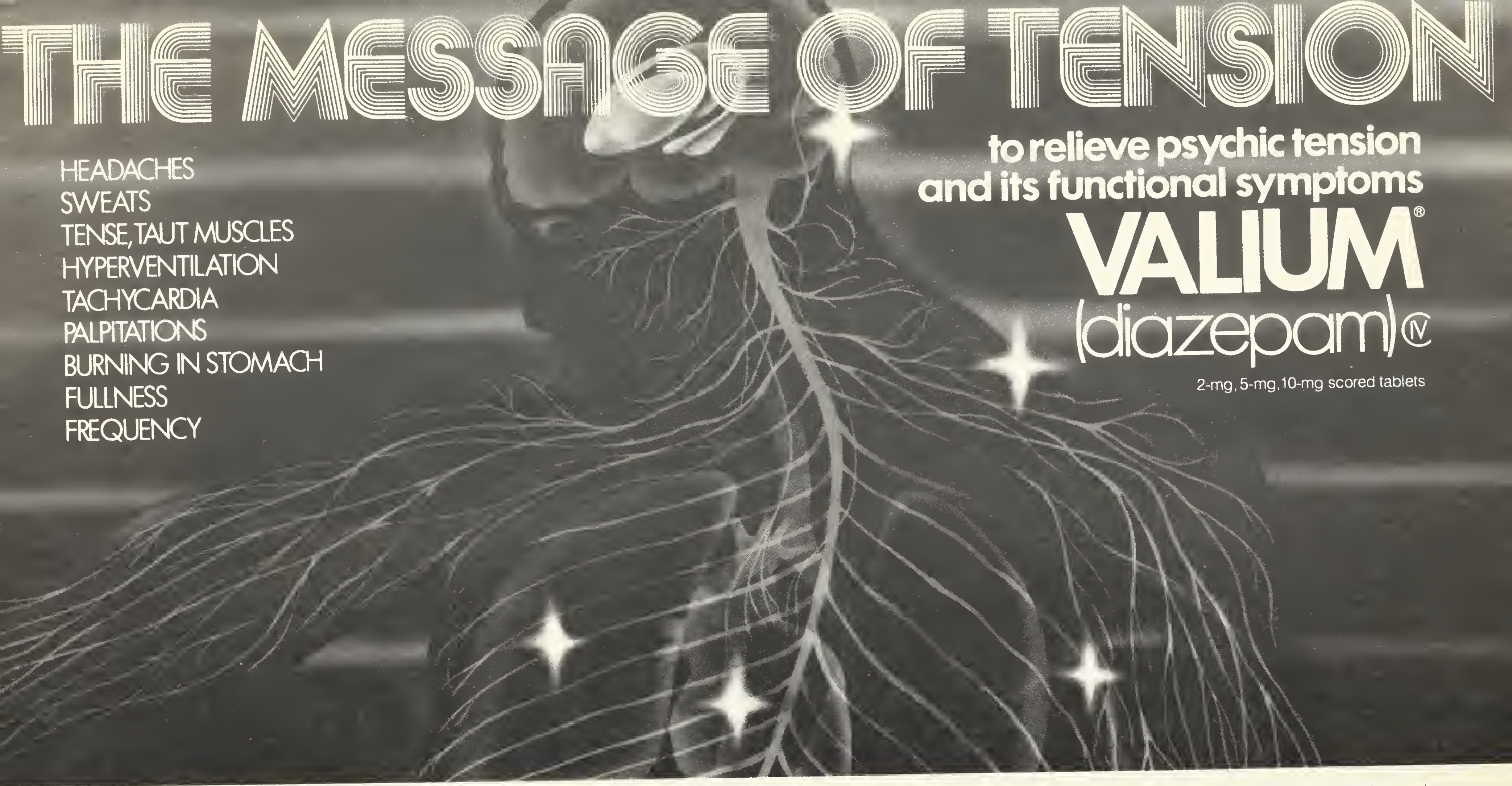
6) To create an awareness in practicing physicians and students about the changing nature and patterns of health care delivery involving personnel, organization and payment systems;

7) To introduce the pre-clinical student to the clinical aspects of medicine as a reinforcement and motivational force in relation to the medical school curriculum.

Participating hospitals

Participating hospitals for the summer of 1978 are: Community Hospital Association and Leila Y. Post Montgomery Hospital, Battle Creek; Hills and Dales, Cass City; St. John, Detroit; Mercy, Grayling; Cottage, Grosse Pointe Farms; Kelsey Memorial, Lakeview; West Shore, Manistee; Marlette Community, Marlette; Hackley and Mercy, Muskegon; Pawating, Niles; Scheurer, Pigeon; McKenzie Memorial, Sandusky; Providence, Southfield; Clinton, St. Johns; Tolfree Memorial, Westbranch; Sturgis and Port Huron.

Further information is available from Mert Scholten at MSMS headquarters, 517/337-1351.



VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia,

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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‘Cost of being a good guy is plenty’

What is the price of being a good guy?

Having just paid my MSMS dues, the same amount as doctors in Traverse City and Detroit, I look back on my 30-odd years of family practice in rural Upper Peninsula and wonder where I went wrong. There was a depression here then. Mines had closed permanently. The giant Ford body plant had stopped making wood station wagon bodies. Most people had let their land go back for taxes. The lumber barons had stripped the virgin land. Men with families were begging for work at 75 cents an hour. But they needed medical care. All doctors' fees were low.

Then people pulled themselves up by their bootstraps. Blue Cross came to be the doctors' own plan to help people help themselves. We agreed to make it work as our answer to socialized medicine. We held to the fee schedules at some sacrifice. Even yet, "I belong," although I am fully aware that auto unions and others in their greed for non-taxable benefits have destroyed the moral goals and lofty ideas of Blue Shield and Blue Cross.

Medicaid and Medicare arrived on the scene, and suddenly I found I was a third class citizen, although a graduate of University of Michigan and board certified member of the Academy of Family Practice. An office call here was and would always be about a third of the same service in Detroit. The simple economics means that my barber nets more for a haircut than I do for a Medicare office call. I found most doctors did not take Medicaid patients. But these rejected people need more medical care than others, so we still see all who come. My state and government have forced me into the role of a medical missionary. The "equality for all" has made me a third class citizen, and the name of the game has become "Let's Get the Good Guys."

And there is insult added to injury. Zone 1 people who have come into their inflated inheritance now retire and have come to our beautiful land. Land costs, building costs, and rents have soared. Food and other costs are higher. It costs as much or more now to run an office in Northern Michigan as in Detroit.

What is the price of being a good guy? Plenty!!

Willard Hayes, MD
Norway

"Please let MDPH know of any chance of fluorosis"

As interested health professionals you must be aware of increasing pressure by anti-fluoridationists and others who are concerned about the total amount of fluorides ingested by the consuming public. As a result of this concern, Governor Milliken in his 1978 State of the State Message stated:

> "In response to these concerns I am directing the Departments of Public Health and Agriculture to conduct a joint study of ingestion of fluoride in Michigan by July 1, 1978. I have asked the departments to pay particular attention to possible health hazards of increased intake."

The Michigan Department of Public Health requests your assistance in determining if there is evidence of an adverse health effect from current total ingestion of fluorides. The argument presented by most opposing the use of fluoride is that our consumption of fluoride in whatever form has increased since the original studies were performed in the 1940's: Thus, we are ingesting an adequate amount for dental health without the use of water fluoridation or possibly contributing to fluorosis.

It has been documented satisfactorily that symptoms of fluorosis can be detected more readily in those with chronic renal disease, on dialysis, low socioeconomic cultures, in tropical climates, etc., at lower levels than would be found in Michigan's general public.

Our request to the physicians of this state is as follows:

1. Would you be on the lookout for the symptoms and indicators of fluorosis and inform the Michigan Department of Public Health of suspected or confirmed cases.
2. The most obvious evidence of fluorosis would be radiographic skeletal changes. Are there X-rays which reveal fluorosis in our general population? (Grand Rapids area physicians notice: Your patients have been using fluoridated water since 1945. Is there any increase in arthritis?)
3. To radiologists throughout the State: Is there a possibility that some cases diagnosed as tumors, osteoarthritis or rheumatoid arthritis, etc., might be due to fluorosis?

Please let the Michigan Department of Public Health know if there is a possibility of any of the above. Address replies to Maurice S. Reizen, M.D., Director, Michigan Department of Public Health, 3500 North Logan Street, Lansing, Michigan 48909.

Sincerely,

Maurice S. Reizen, MD
Director
Michigan Department
of Public Health

Michigan Medicine takes first place in national competition

Michigan Medicine, the official MSMS journal, is the recipient of the first place award in its category in a national medical journalism awards project.

Announcement of *Michigan Medicine*'s first-place finish for state medical journals of 3,000 or more circulation was made in mid-April by the Sandoz Pharmaceutical Company, sponsor of the competition.

A plaque and $500 award will be presented to the editors July 8 at Deer Lake during the Midsummer Meeting of the MSMS Council. Sandoz has sponsored medical journalism workshops and contests for several years under the direction of University of Missouri School of Journalism Professor Paul Fisher, PhD.

In announcing the award, Craig D. Burrell, MD, head of external affairs for Sandoz, commented, "We are delighted that this year's entries were more numerous and greatly improved in design and editorial quality over entries of previous years. This made the judging extremely difficult."

The Sandoz awards are for outstanding appearance and editorial qualities. *Michigan Medicine*, which competed with the largest number of entries for any of the categories, was cited for its major changes in format every year "made to stimulate current and new readers."

"Duotone photos on the covers, convenient location of contents page on inside front cover, line drawings, cover and special articles printed on colored paper, effective use of several colors for headlines, efficient use of bold-face type, crisp editing, omission of "jump articles, and other innovations," continued the announcement letter, "are indicative of great effort and creativity."

Michigan Medicine is published monthly and is unusual in its omission of research and clinical reports. Since January, 1976, it has concentrated on medical and related news of interest to physicians in the state.

Executive editor is Herbert A. Auer, deputy director and head, MSMS Division of Public Service, Communications and Physician Education. Managing editor is Judith Marr. Advisors for *Michigan Medicine* are members of the MSMS Committee on Publications, headed by James H. Tisdel, MD, Port Huron. The journal is printed by Wellman Press, Lansing.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of QUARZAN® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

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*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

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DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

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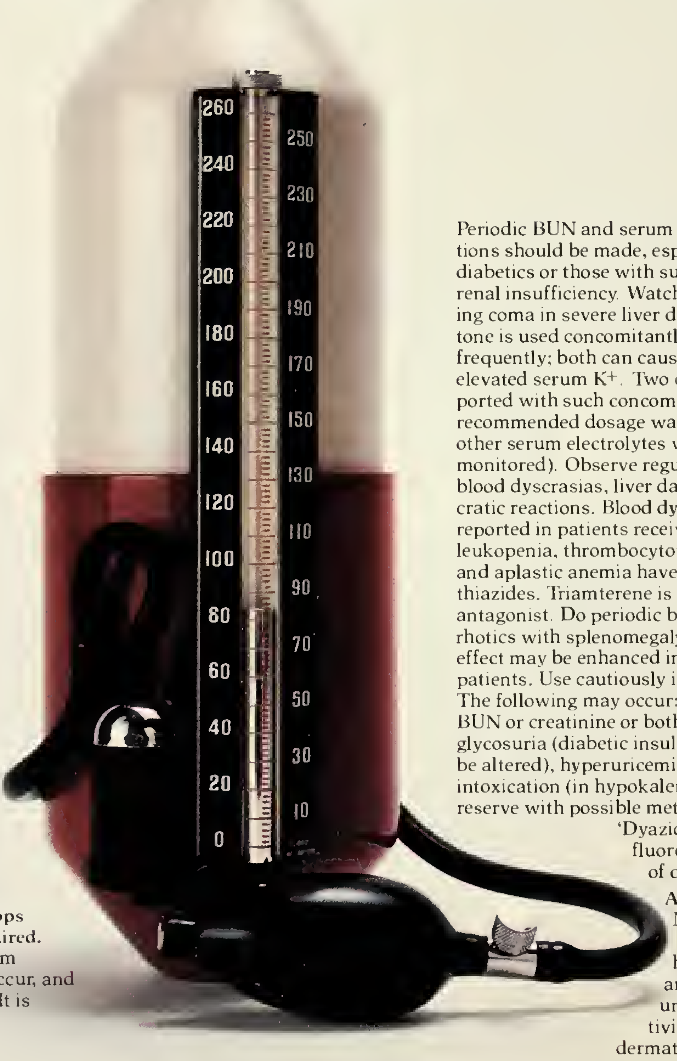

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.*
SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)

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Late in April, Detroit physicians Carl and Marjorie Stewart Gagliardi served as MSMS "doctors of the week." During the week they hosted a reception at MSMS headquarters for all Detroit-area legislators.

Among the friends they greeted was Rep. Ray Hood, chairman, House Public Health Committee, above center. Carl Gagliardi, MD, is president of the Wayne County Medical Society and an MSMS councilor.

MSMS reception gathers Detroit legislators

Grouped in intense conversation during the reception were, from left, James D. Fryfogle, MD, Detroit, speaker of the MSMS House of Delegates; Rep. George Cushingberry Jr., and Gerald Mandell, MD, Detroit, active MSMS committee member.

Arthur Ulmer, MD, Detroit, WCMS past president, left; and William T. Unkefer, MD, Detroit, center, met during the reception with Rep. Matthew McNeely, chairman, House Insurance Committee.

GAGLIARDIS/*continued*

Also at the reception were, from left, Jose V. Valdez, MD, Detroit; Rep. Joseph F. Young and Rep. Thomas J. Anderson, chairman of the House Committee on Conservation, Environment and Recreation.

MSGS reactivates in 1978

The Michigan Society of General Surgeons has reactivated, with plans for quarterly meetings and an active membership of 329 physicians.

Peter A. Duhamel, MD, Rochester, is president. President-elect is Charles S. Rogers, MD, Bay City. Glenn E. Moore, MD, Flint, is secretary-treasurer.

The surgeons plan a newsletter, with a tentative four mailings a year. Doctor Moore has agreed to serve as editor. The first newsletter is to carry a fee questionnaire asking what members charge for various services, what Blue Shield pays members for those services, and whether members participate with Blue Shield, and on what basis.

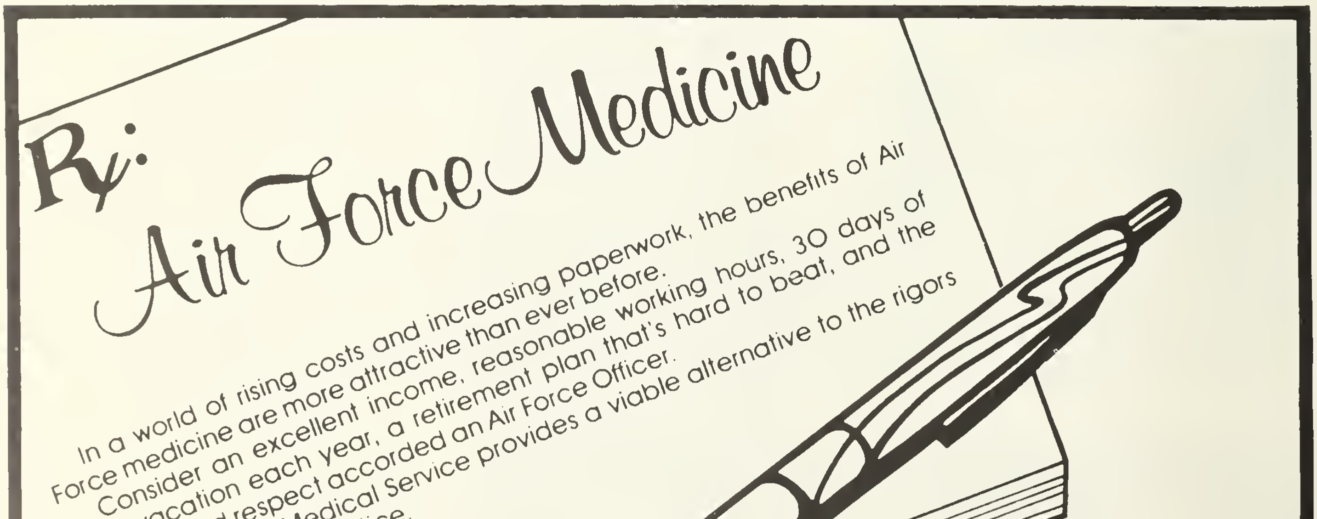
Health, nutrition survey underway

The US Public Health Service has begun visits in Cheboygan-Emmett, Ionia-Montcalm, and Wayne Counties to conduct the Health and Nutrition Examination Survey of persons aged six months through 74 years.

The initial phase in Cheboygan-Emmett Counties began June 5, with interviewers from the US Bureau of the Census calling on selected households to obtain certain demographic information to identify and select about 524 persons for the examination.

Examinations will be conducted from June 28 through Aug. 5 in one of the survey's mobile examination centers.

In Ionia-Montcalm Counties, interviewing to select about 483 persons will begin on July 24, with examinations being conducted from Aug. 11 through Sept. 16. In Wayne County, interviewing to select about 585 persons will begin July 31, with examinations from Aug. 11 to Sept. 23.



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At the MSMS Liaison Committee's reception for Medical Practice Board members were, from left; board members John F. Fennessey, MD, Grosse Pointe; Board Chairman John R. Wilson, MD, Grand Rapids, and Donald H. Kuiper, MD, Lansing.

Board chairman Wilson chats with MSMS staff assistant to the liaison committee, Sherry L. Wellman.

Board member Henry Kallett, MD, Jackson, left, meets with liaison committee member Louis R. Zako, MD, also chairman of the MSMS Council.

MSMS Liaison Committee gathers state board members

By Katie Brewbaker, MSMS staff

The Liaison Committee with the Medical Practice Board hosted the full Medical Practice Board for dinner and joint exchange of ideas and expression of concerns on May 3.

The official function of the Liaison Committee is to consult with the Michigan Medical Practice Board or its representatives on issues associated with the licensure of doctors of medicine in Michigan. Relevant MSMS policy is transmitted to the board through the committee, and it reviews and recommends to The Council candidates for appointment to the Board for transmittal to the Governor. The committee directs MSMS staff attendance at meetings of the board and the reports to the MSMS membership.

The Liaison Committee meets with the Board quarterly, or more frequently if necessary.

Matters that have been of particular concern during the past few months are revision of the CME rules to implement accumulation of 150 hours of CME credit over a three-year period rather than requiring physicians to acquire 50 hours annually to qualify for re-licensure, and the elimination of the witness requirement from the CME reporting form. The board has acted favorably on both of these issues.

Still at issue are the rules for utilization of physician assistants.

At the May 3 meeting, the representatives of the Michigan Medical Practice Board asked MSMS for its increased assistance in the board's efforts to retain its autonomy and constitutional prerogatives, in face of infringement from the state bureaucratic system.

Time is the test of all things.

BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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(potassium gluconate)
20 mEq per 15 ml

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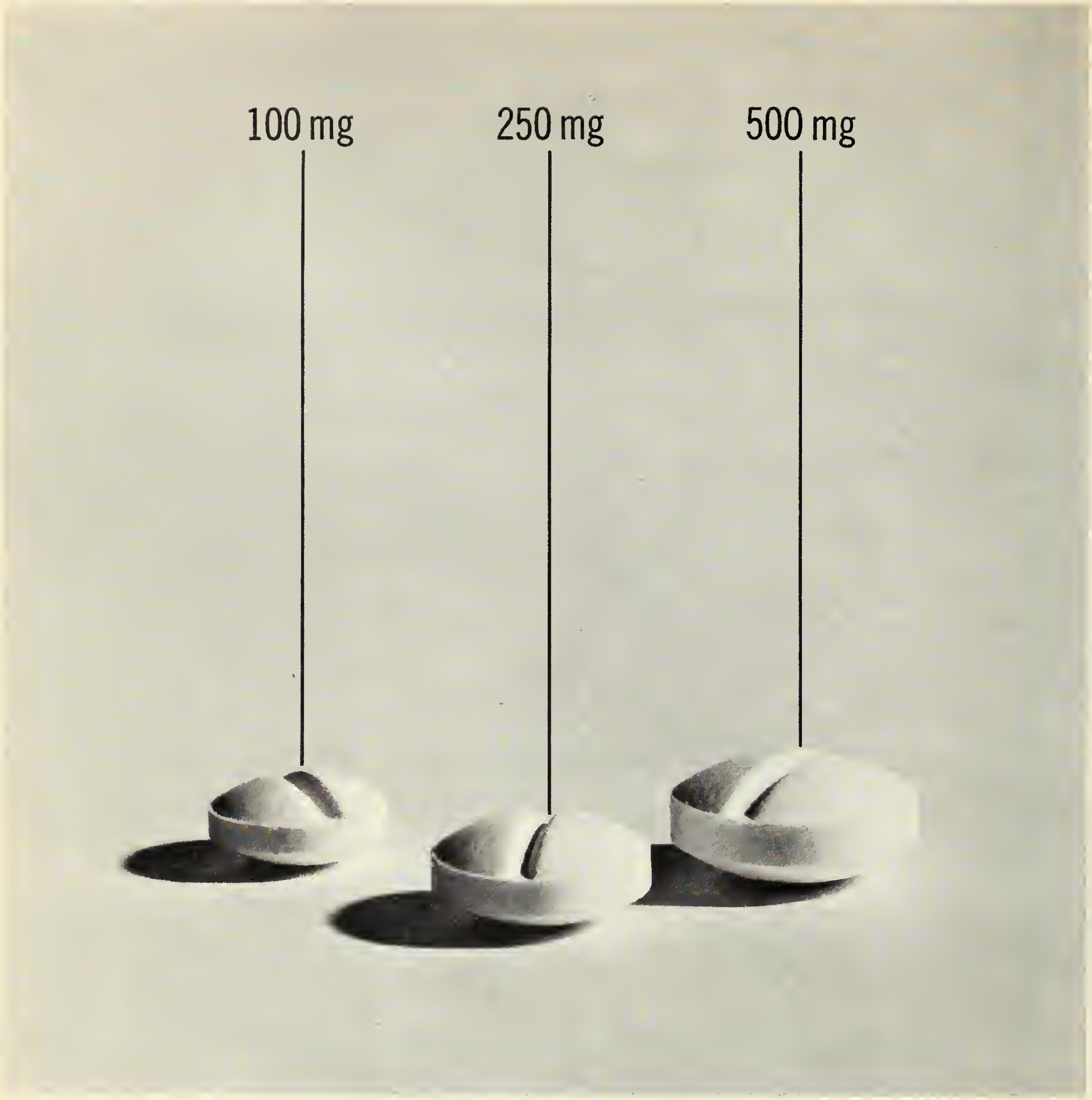
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Here's the latest information on HMOs now developing in Michigan

By Richard M. Campau, Manager
MSMS Department of Health Care Delivery

What is the picture nationally in regards to HMOs?

A mid-1976 census conducted through the combined efforts of the Blue Cross Association, the National Association of Blue Shield Plans, and HEW showed:

A. 175 pre-paid health plans in operation, covering 6,106,443 members.

B. 64 percent of the total HMO membership is in the West, 50 percent in California.

C. Inpatient hospital utilization for all plans is 449 days per 1,000 members per year.

D. Physician visits per member per year for all plans average 3.8.

In Michigan, there are 10 HMOs in various stages of development under PA 264 of 1974. (See table)

Currently Licensed HMOs (as of 4/11/78), include:

Name	Location	Estimated Enrollment
1. Total Health Care	Detroit	7,000
2. Comprehensive Health Services of Detroit	Detroit	27,000
3. Michigan HMO Plans, Inc. (independent practice Association)	Detroit	27,085
4. Metro Health Plan	Detroit	75,000
5. Total Care	Lansing	no enrollment
6. Family Health Care Plan	Kalamazoo	4,000
7. Group Health Service of Michigan	Saginaw	5,000
8. Group Health Plan of Southeast Michigan*	Warren	3,000
9. Health Central*	Lansing	1,500
Under Development		
10. Genesee Health Care Corporation (independent practice association)	Flint	

(*Federally qualified — access to loan funds, dual choice requirement goes into effect)

New HMO legislation

There have been three major new developments in legislative action regarding HMOs in Michigan.

On July 7, 1977, Senate Bill 822 was introduced by Senators Otterbacher and Faust and referred to the Committee on Health, Social Services and Retirement. This bill would:

1. Change several sections in the current state HMO law in line with the recently passed federal amendments to the federal HMO act.

a. The dual option base would be predicated on location of employee, not employer.

b. Unions or collective bargaining groups would decide the HMO option for employees, and select the HMO (employees would make individual decisions to join or not to join as under present law).

2. Reduce basic benefits now required by present law to:

a. physician services

b. inpatient/outpatient hospital services

c. emergency health services

d. short term visits (not to exceed 20) for outpatient

e. diagnostic lab and x-ray

f. preventive health services

3. Delete the HMO Commission from the Act.

4. Conduct licensing and regulation by one agency, Department of Public Health. (Currently both the Public Health Department and the Bureau of Insurance have responsibility for regulation. This has created confusion and conflicts, both for HMOs and for the two agencies.)

5. Permit universities, hospitals, public agencies and corporations to develop HMOs and maintain control. (The University of Michigan, Michigan State University, Ford Motor and Upjohn are now conducting feasibility studies.)

6. Allow an HMO to declare its service area rather than the Department of Public Health doing so.

7. Minimize reporting requirements to reduce paperwork and unnecessary interference in the day-to-day operations of the HMO.

8. Establish Quality Assurance Programs by the HMO; not dictated by the Department of Public Health. (The Department of Public Health would approve and monitor such plans.)

Mr. Campau

9. Permit arrangements and oral agreements with affiliated providers (hospitals) that are not in writing if the HMO has a history of past relations or can show that written contracts cannot be obtained.

SB 821

On July 7, 1977, Senate Bill No. 821 was introduced by Senators Otterbacher and Faust and referred to the Committee on Health, Social Services and Retirement. This bill would:

1. Establish an Ambulatory Health Services Commission (13 members appointed by the Governor with the consent of the Senate), to replace the current HMO Commission.

2. Establish an independent Office of Ambulatory Health Services Development in the Department of Public Health to:

a. provide necessary staff assistance to the Commission

b. assist organizations in the preparation for licensure as an ambulatory health service

c. provide technical assistance for the development of ambulatory health services

d. review, recommend and develop programs which would assure the quality of care in ambulatory health services.

e. administer grant programs and coordinate with other agencies in the allocation of resources for ambulatory health services

f. conduct educational programs for employers regarding the dual option for HMOs

g. conduct feasibility studies on quality of care and cost containment.

3. The act shall expire four years after its effective date.

SB 823

On July 7, 1977, Senate Bill No. 823 was introduced by Senators Otterbacher and Faust and referred to the Committee on Health, Social Services and Retirement.

This bill would amend Section 11 of PA 17 of 1968 to prohibit hospital governing boards from:

1. Denying staff appointments to physicians solely on the basis of their affiliation with a Health Maintenance Organization, and

2. Discriminating against a Health Maintenance Organization which desires to enter into a contract or agreement for inpatient services.

MSMS Policy on HMOs is as follows:

MSMS recognizes "that there are many acceptable methods of practicing medicine" and "feels strongly that, as various programs evolve, multiple options for the delivery of medical care should remain open to physicians." This was established with passage of the MSMS House of Delegates Resolution #15 in 1970.

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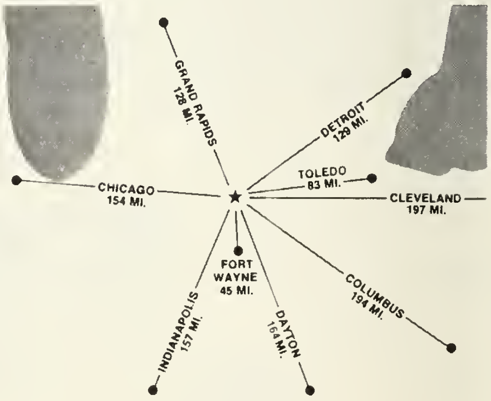
It has many friendly communities, where you can enjoy living and raising a family, which need and want the services of both family practitioners and specialists.



For more information, contact Wendell Jacob, Chairman Physician Recruitment Committee, 15 South Public Square, Angola, Indiana. 46703. (219) 665-3194.

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Category I courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: June 16-18, "Exploring the Effects of Mid-career Stresses Upon the Medical Family." Location: Meadowbrook Hall, Oakland University. **Sponsor:** Michigan Psychiatric Society. **Co-sponsor:** Michigan State Medical Society. **For:** Physicians and spouses. **Cost:** $12 per credit hour. **Contact:** Committee on Well-being of Physicians, Michigan Psychiatric Society, Box 950, East Lansing, 48823. **Approved for:** 18 hours of Category I Credit.

Date: June 22-24, Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $25. **Contact:** Wayne State University, Division of CME,** or Benjamin E. Henig, MD, 308 Michigan Ave., Grayling, 49738. **Approved for:** 12 hours of Category I Credit.

Date: June 23, Joint Scientific Meeting. Location: Detroit Plaza Hotel. **Sponsor:** Michigan Thoracic Society-American College of Chest Physicians. **Co-sponsor:** Michigan Lung Association. **For:** Physicians interested in pulmonary disease. **Contact:** Michigan Lung Association, 403 Seymour, Lansing, 48914. **Approved for 10 hours of Category I Credit.**

Date: June 23-25, Urology Outing. Location: St. Clair Inn, 500 N. Riverside, St. Clair, 48079. **Sponsor:** Wayne State University School of Medicine, Div. Continuing Medical Education. **Cost:** $125. **Contact:** Wayne State University School of Medicine, Div. of CME.** **Approved for:** 12 hours of Category I Credit.

Date: June 25-30, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $200. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21½ hours of Category I Credit.

Date: June 28, Psychiatric Problems as Encountered in Family Practice. Location: Edward W. Sparrow Hospital, Lansing. **Sponsor:** Department of Family Practice, E. W. Sparrow Hospital. **Co-sponsor:** Michigan Academy of Family Physicians. **Cost:** None. **Contact:** Jean Machtel, CME Secretary, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., P.O. Box 30480, Lansing, 48909. **Approved for:** 4 hours of Category I Credit.

Date: June 28, Use of the Rast Procedure in Medicine. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital Continuing Medical Education Department. **Contact:** Medical Education Office, 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: June 29-30, Mental Health in Aging. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology and U-M Medical School. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, University of Michigan, 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

Date: July 11-13, Annual Educational and Social Meeting. Location: Boyne Mountain Lodge. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **Cost:** None. **Contact:** Robert S. Holm, MD, Michigan Chapter Chairman, American Academy of Pediatrics, 515 Lakeside Drive, S.E., Grand Rapids, 49506. **Approved for:** 7 hours of Category I Credit.

Date: July 21-22, Mental Health Audit Seminar. Location: Hilton Inn, 7501 W. Saginaw Highway, Lansing. **Sponsor:** Interqual, Chicago. **For:** All mental health professionals. **Cost:** $150. **Contact:** Monica Eckart, Seminar Registrar, 312/751-2327, or 800/621-6109. **Approved for:** 12 hours of Category I Credit.

Date: July 27-28, 1978 Coller-Penberthy-Thirlby Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center, Traverse City. **For:** All specialties. **Cost:** $25. **Contact:** Thomas Auer, MD, % Munson Medical Center, Traverse City, 49684. **Approved for:** 9 hours of Category I Credit.

Date: July 29-August 2, 32nd Annual Convention and Scientific Assembly, Michigan Academy of Family Physicians. Location: Sugar Loaf Village, Cedar. **Sponsor:** MAFP. **Cost:** $65 members, $75 non-members. **Contact:** Rita Feldkamp, (313) 455-4200. **Approved for:** 30 hours of Category I Credit.

Date: July 31-August 4, and November 6-10, Principles of Milieu Practice: Working with the Elderly in Treatment Settings. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 35 hours of Category I Credit.

Date: Sept. 13, Third Annual Renal Disease Conference. Location: Kalamazoo Center, 100 West Michigan, Kalamazoo, 49006. **Sponsor:** Michigan Nephrology Center. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians, Internists, General Practice, Nephrologists. **Cost:** $35. **Contact:** Jeffrey Block, M.D., Michigan Nephrology Center, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 21, 22, 23, Implant Surgery for Joints and Tendons in the Hand. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Cost:** $200. **Contact:** Alfred B. Swanson, MD, Chairman, 290 Blodgett Professional Bldg., Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 28-29, Coping with Changes in the Later Years. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 30, Michigan Society of Pathologists September Seminar, "Cardiovascular Diseases." Location: Sinai Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: Oct. 6, 7, 8, Annual Meeting, Michigan Chapter of the American College of Physicians. Location: Otsego Ski Club, Gaylord. **Sponsor:** Michigan Chapter, American College of Physicians. **Contact:** Boy Frame, MD, FACP, ACP Governor for Michigan, 543 Lakepointe, Grosse Pte. Park, 48230. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 18, Diabetes for the Clinician. Location: Kalamazoo Center, Kalamazoo. **Sponsor:** American Diabetes Association, and The Upjohn Company. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Family physicians and internists. **Cost:** $25 physicians, $10 house officers. **Contact:** C. L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 252 East Lovell Room 364, Kalamazoo, 49006, (616) 383-6360. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 2, Second Annual Michigan Family Practice Research Day. Location: MSU University Club, East Lansing. **Sponsor:** Department of Family Practice, MSU College of Human Medicine, and Michigan Academy of Family Physicians. **Contact:** Doug McKeag, MD, Chairman, Research Day Planning Committee, MSU Department of Family Practice, East Lansing, 48824, 517/353-0850. **Approved for:** 9 hours of Category I Credit.

Date: November 6-10, Counseling Older Adults and their Families; Principles of Milieu Therapy: Working with the Elderly in Treatment Settings. Location: University of Michigan. **Sponsor:** Institute of Gerontology, University of Michigan. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 3.5 hours of Category I Credit.

Date: Nov. 7-9, MSMS Annual Scientific Meeting. Location: Detroit Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** MSMS. **For:** All specialties. **Cost:** $3 per hour for members, $15 per hour for non-members. **Contact:** Herbert Auer, MSMS headquarters, 517/337-1351. **Approved for:** 20 hours of Category I Credit.

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***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

MHA survey reveals attitudes on medical costs

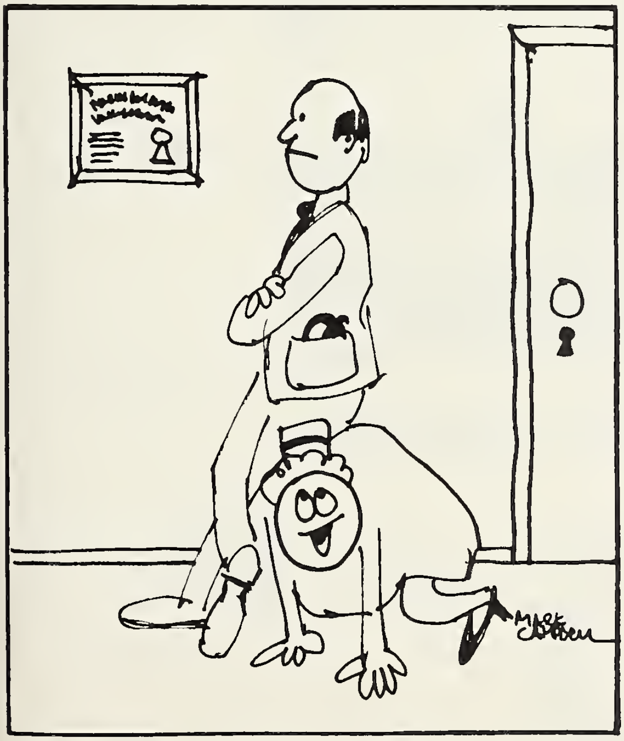
Michigan residents who have had the most recent experiences with hospital bills — those who have been in a hospital and have seen the services hospitals provide — are less likely to think costs are out of line than those who haven't been in a hospital for a while.

This was one of the most interesting findings from a survey on public attitudes toward Michigan hospitals conducted in mid-February by the Michigan State University School of Journalism. Results were released to the public in mid-April.

Other results show respondents oppose paying any portion of hospital bills from their own pockets, oppose closing smaller hospitals in favor of regional centers even if closings would save money, think more government rules will not hold down costs or improve care, and believe inflation is the single most important cause of rising hospital costs.

Two-thirds of the respondents think Michigan hospital care is good or excellent and think care is at least as good as 10 years ago. Three-quarters give hospital employees high marks for friendliness, though only a third say they get adequate explanations for treatments and medicines.

The Michigan Hospital Association's Committee on Public Affairs is working with the Michigan Hospital Public Relations Association (MHPRA) to write an analysis of what these results mean to the MHA and its members. That analysis will be completed shortly.



"Okay, okay. I'll wash the bedpans and you dry." (Cartoonist Doctor Campbell is beginning a residency in oncology in Detroit and regularly supplies cartoons to *Michigan Medicine*.)

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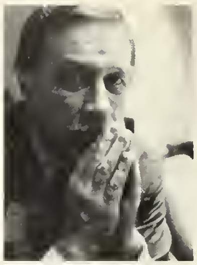
Two Michigan men key figures in London conference this summer

Doctor Evans



Mr. Tryloff

Her Majesty the Queen is patron of a world-wide conference in London this summer which two well-known MSMS'ers have helped plan and promote.

The Advances in Medicine (AIM) conference, sponsored by the Royal Society of Medicine and RSM Foundation, Inc., is scheduled next month at Wembley Conference Centre, London, July 23-28.

Tommy N. Evans, MD, Detroit obstetrician and gynecologist, was chosen by the Royal Society of Medicine to serve as one of the two advisory panelists for the conference, and has taken an active role in planning program content and selecting speakers. The AIM Conference is billed as a World Conference on the Inter-relationship of Specialties to Major Diseases.

To help in an administrative capacity, the Royal Society of Medicine called upon MSMS Director Warren R. Tryloff regarding the promotional aspects of the conference for the United States and Canada. In addition, he is serving as a consultant to the London conference planners.

Advances in Medicine is intended for doctors in all specialties, and it is expected over 2,000 physicians from all over the world will attend.

Some of the major areas to be covered are oncology, immunology, biochemical and metabolic aspects, pharmacology and therapeutics. Each day begins with a plenary session, followed by breakout sessions on such subjects as Diseases of the Breast, Gastroenterology, Bone and Joint Diseases, and Cardiovascular and Related Diseases. Also, there will be a session on the management and cost of health care, comparing systems in four countries.

The AIM Conference has been approved for 27 cognates by the American College of Obstetricians and Gynecologists.

Additional information may be obtained by contacting either Warren Tryloff at the MSMS office, Box 950, East Lansing 48823 (517) 337-1351, or by writing directly to the conference organizers in London, Conference Services Limited, 43 Charles Street, Mayfair, London W1X 7PB, England.

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'Ancef' may be given either IM or IV at the same dosage schedule.

Most infections can be treated with 500 mg. to 1 gram every 8 hours.

(See complete prescribing information in *PDR* or SK&F literature for full dosage instructions.)

Well Tolerated

Infrequent phlebitis; no nephrotoxicity reported. Transient rises in BUN, SGOT, SGPT and alkaline phosphatase have been reported without clinical evidence of renal or hepatic impairment.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

Respiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus.*

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of non-susceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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Speaker Crim: social compact likely in health

By Willah Weddon
Special to Michigan Medicine

The following article is the sixth in a series. The articles, written especially for *Michigan Medicine* by Lansing-area free-lancers, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.

Speaker of the House Bobby D. Crim (right), D-Davison with Rep. Raymond W. Hood, D-Detroit, on the House floor.

"Although the continuing medical education (CME) program was designed as a method to assure competence, we have found that it really doesn't," contends Speaker of the State House of Representatives Bobby D. Crim. "Like licensure, it still emphasizes inputs rather than outputs."

The concern of the state should not be simply to measure the credentials an individual brings to practice, but to assess periodically the individual's ability to continue providing quality care, he explains.

"The proposed Public Health Code addresses this question directly," he says. "It mandates that over a six-year period, all of the various licensed health professions undertake a study to determine how best to assure continuing competence within our existing technology. Within six years, a continuing competence program is to be designed and put into place."

What the program will be, Crim cannot predict. It will involve the thinking of a variety of people and a variety of different perspectives.

CME must be effective

"But we know this for sure! CME places an added responsibility on our health care professionals without clearly meeting the objectives that were set forth for it," he said. "It should not be discarded immediately because we are still learning from it. But we should move as rapidly as possible to develop programs to meet our objective of continuing competence; working cooperatively to assure that we end up with an effective program."

Crim, who has a master's degree from the University of Michigan, began a teaching career in Davison Community Schools in 1959. Within five years he became active in the Democratic party and was elected to a lone term as a state representative in 1965.

Four years later he returned to the Capitol as executive secretary to then Speaker of the House William A. Ryan (D-Detroit). In 1973 Crim was elected to a second term in the house, became the majority floor leader and following re-election in 1975, was named speaker of the house.

Meanwhile, his scholarly habits have been retained. It's well known he doesn't like to be disturbed when he's busy on the house floor and when he explains an issue it is thoroughly covered in school-master fashion and tones. He's respected for his hard work and, rating next to the Governor in prestige, has worked with him in drafting state policy.

One of the first major hurdles facing Crim as speaker was the medical liability crisis. He was influential in steering many vital bills through the house, including the establishment of the State Medical Liability Insurance (Brown-McNeely) Fund. He has also been a staunch supporter in the attempt to obtain adequate funding for the Medical Practice Board.

Government's role & response

The increasing role of government in domestic programs, including health, is viewed by Crim as a response to public demand.

"With government now providing over 40 percent of the total dollars spent for the provision of health services in this country, the public will always have a legitimate interest in how that money is expended and what it purchases," he said thoughtfully. "The role of government, however, could change substantially. Over the past 10 years I think we have come to see there are severe limits on what large public bureaucracies can do well or not at all."

Crim sees a social compact developing in the health area particularly, with cooperation and voluntary participation of consumers, providers and government evolving solutions to health problems.

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For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

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Views

Working together: hospital administrators and staff

(The articles on these two pages were written in response to the editors' question: How can physicians and hospital administrators work better together?)

By Alexander Blain III, MD
Grosse Pointe

Problems which exist between the medical staff and the administrations of hospitals can be ameliorated by better communication.

Techniques to achieve better communication include regular meetings between doctors, administrators and members of the hospital Board of Trustees. This can be partially achieved by electing several practicing physicians to the hospital Board — I mean physicians who are in private practice and who admit patients to the hospital.

Another mechanism is the "joint conference committee" as established by the Joint Commission of Accreditation on Hospitals. This may be composed by the elected officers of the medical staff and the elected officers of the hospital governing board. This committee must meet regularly.

The administrator who is executive head of the hospital should be elected to the Board of Directors just as in industry. Also, the administrator should be a member of the joint conference committee and an ex-officio of the medical staff executive committee.

Doctor Blain

Doctor Wilhelm

Various hospital social events should afford future contacts for the physicians and the Board of Trustees. These would include annual functions at which awards are given to hospital employees for cost cutting ideas, as well as birthday parties, annual Christmas parties and other social events.

In spite of all the foregoing mechanisms to improve communication, there will be times when the difference in emphasis associated with various positions can set one group against another. For example, the doctors may desire an expensive piece of equipment to improve medical diagnosis and treatment, whereas the Board of Directors is trying not to spend more money than the hospital revenues will afford. A decision one way or the other or a compromise must be achieved amicably with each group understanding the views of the other.

Outsiders may get in the way of this relationship. This must be understood by physicians, Boards of Trustees, and administrators. Examples of this vexation include those bureaucrats who decide on the basis of demographic studies and statistics (which can be used to prove anything) that a certain geographic area will require more or less beds 10 years from now, or indeed more or less hospitals 10 years hence. We still remember their past overselling of the idea that hospital efficiency is directly related to the number of beds, i.e., the larger the hospital, the more efficient and economical it should be. It did not take many years to disprove this. We now know that some hospitals, usually the smaller ones, are best suited for primary care, while others are best utilized for special services such as cancer chemotherapy, burn therapy, open heart surgery, total hip replacement and the use of expensive equipment such as linear accelerators. Duplications not only help the cost of medical service to skyrocket but promote bad medicine and overutilization of facilities.

In this respect, the planning of civilian hospital locations, size and functions can profit from the superimposition of military type health care planning on our present existing Michigan facilities. Some older facilities need to be phased out and newer ones constructed. Doctors now do not have much to say about when or where, and they should — for surely there are too many incompetent nonphysicians cluttering up the decision-making process in the area of planning. This confuses hospital administrators and board members. Practicing physicians can help to overcome this confusion as they are closest to the patients' needs and are more critical of "statistics."

The military services rely on medical advice in the planning and operation of hospitals and dispensaries and they maintain open channels of communication between doctors and administrators.

With greater understanding comes greater mutual respect and the replacement of friction with a coordinated team approach to hospital operation and patient care.

Not only are hospitals devoted to patient care but also to research (even into their staffs' clinical results) and teaching. Physicians teach one another, nursing and other departments and not least of all, patients.

Busy physicians lack the time and expertise to attend to the numerous details of hospital administration but let no one forget that hospitals without participating physicians are not really hospitals at all. Likewise, hospital policy lacking physician participation is not in the public interest.

Doctor Blain, a surgeon, was for many years medical director of the Alexander Blain Memorial Hospital of Detroit. He has recently become medical director of the Budd Company, Detroit plant.

Understanding, respect, trust, unselfishness needed

By Daniel J. Wilhelm, MD
Port Huron

A tough question! How does one change attitudes and feelings of physicians, administrators, and hospital directors? Can the tasks and duties of each be met on principles based on mutual respect? Can we make our decisions and guide our actions according to what is best for our patients?

I have experienced some attitudes and personality types which adversely affect good working relationships. Among administrators:

1. Personality Self-Importance: "I can do it all myself. I don't need any input from anyone else. No one else can possibly have anything important to contribute."

2. Personality Self-Ambition: "I want my hospital to be THE medical center. Look what *I've* done to add medical facilities here. I certainly don't want any expensive duplication of medical facilities in our area, but I want *this* hospital to be a full-service hospital, etc., etc."

3. Personality Alienation: "You doctors have been living off the fat, and I don't expect any of you will want to sacrifice a little and help with this problem. I don't expect any of you who won't accept poor MEDICAID patients to show any concern about this. You doctors don't need to be concerned about costs of care, etc., etc."

4. Personality Gamemanship: "I'd like a new surgical suite here; and maybe if I put new furniture in the OB lounge and give pediatrics another nurse, the medical staff won't question the need for another surgical suite."

Then there are the physician personality types which adversely affect understanding:

1. The Loner: "I don't want to know about any problems. Just let me care for my patients. Don't put me on any committees — I don't have anything to offer."

2. The Griper: "Nothing's right around here. The administration is stupid. I'll tell everyone what's wrong, but I won't try to find out how to help."

3. The Selfish One: "I don't have time for any involvement. My other interests are more important. Don't put me on any committees — I won't attend. But I'll suck up all the benefits brought about by the hard work of others."

4. The Resentful One: "The administration didn't see it my way on that other concern of mine, so I'll not help on this one. How can I make them look bad?"

Certainly, it's impossible to expect the medical staff and hospital administration to always work together without some disagreement. But, personal ambitions and motivations must not be allowed to affect decisions which determine what is best for the patient. More can be achieved by understanding, respect, trust, and an unselfish attitude.

Doctor Wilhelm is a pediatrician in private practice.

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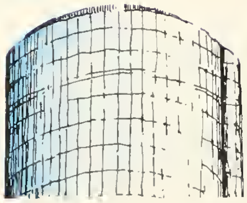
Coming Up Soon for MSMS Members

MSMS Annual Scientific Meeting, Nov. 7-8-9

Coming soon in Michigan Medicine will be some of the details for the 1978 MSMS Annual Scientific Meeting. Physicians will again be able to combine a mini-vacation with the spouse with the chance to earn Category I CME credits.



MATERNAL HEALTH DESK REFERENCE CARD NO. 22

(Sponsored and Prepared by the Committee on Maternal and
Perinatal Health, Michigan State Medical Society)

GESTATIONAL TROPHOBLASTIC NEOPLASMS

Gestational trophoblastic neoplasm (GTN) is a term used to describe a group of related tumors associated with pregnancy. These range from hydatidiform mole or molar pregnancy through choriocarcinoma. The common denominator is the ability of the trophoblastic tissue to elaborate human chorionic gonadotropin (hCG). This allows for unique diagnosis and follow-up.

Human chorionic gonadotropin can be detected in urine and blood. A variety of methods such as bioassay, radioimmunoassay, radioreceptor assay and beta subunit radioimmunoassay are available for the assay of hCG both in blood and urine. At present the most sensitive and specific of all is the beta subunit RIA, which is able to detect as low as 0.01 I.U./hCG/ml. serum.

Diagnosis is suspected in patients with evidence of pregnancy who have bleeding and uterine enlargement greater than gestational age. In slightly less than half the patients this enlargement will be compatible with dates. Signs and symptoms of pre-eclampsia, hyperemesis, hyperthyroidism, trophoblastic embolization and disseminated intravascular coagulation may be seen.

The diagnosis may be made by ultrasonography or amniography. Elevation of urinary hCG excretion greater than 1,000,000 I.U./24 hours is highly significant although multiple gestation must be considered when diagnosing GTN and must be excluded when high levels are reported. The best means of assay of hCG is the serum hCG beta subunit determination with levels greater than 0.15 I.U./ml. being significant.

In the case of hydatidiform mole, suction curettage is the treatment of choice, and must be followed with sharp curettage of the placental site to assist in diagnosis. If initial pathology reveals invasive mole or choriocarcinoma the patient must be treated with appropriate chemotherapy immediately.

If the initial pathology is hydatidiform mole then the *minimal* investigation is:

Initially:
1. hCG assay at evacuation and weekly thereafter.
2. Chest x-ray at evacuation and at four and eight weeks.

Recommendations:
1. If hCG level becomes normal for 3 consecutive weeks, then repeat hCG titer monthly for 6 months and avoid pregnancy during that interval.
2. If hCG level plateaus or rises for more than 2 consecutive weeks, or if metastases appear, treat with appropriate chemotherapy.
3. Consultation regarding management of the case is strongly urged.
4. Appropriate contraception for the 6 months post-evacuation is strongly recommended.

Assistance in evaluation of patients, laboratory support and follow-up may be obtained from the:

Ann Arbor Trophoblastic Center
Department of Obstetrics and Gynecology
University of Michigan Hospital
Ann Arbor, Michigan 48109

Phone (313) 764-8123

REFERENCES

1. ACOG Technical Bulletin, Number 33, August, 1975, "The Management of Molar Pregnancy."
2. Goldstein, D.P., Kosasal, T.S., Skarian, A.T., "The Clinical Application of a Specific Radioimmunoassay for Human Gonadotropin in Trophoblastic and Non-Trophoblastic Tumors," Gynecolog. & Obstet., 138: 745-751, 1974.

Prepared for the Committee on Maternal and Perinatal Health, Michigan State Medical Society by Bruce A. Work, Jr., MD, Ann Arbor.

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News

By Katie Brewbaker,
MSMS Staff

Over 50 years ago **Doctor James J. McClendon's** mother urged him to leave Rome, Georgia, and head north "to stay out of trouble." Seems Doctor McClendon had taken exception to an insurance man calling his mother "Louisa" rather than Mrs. McClendon. Now an active 80 and still practicing medicine, this leader in the Detroit Chapter of the NAACP hasn't lost any of his determination. As he explained in Frank Angelo's recent *Detroit Free Press* column, "I hate injustice . . . I just hate it . . . It has no place in our society. I have believed all my life in the equality of mankind." The NAACP honored Doctor McClendon for his long devotion to the Civil Rights cause at its 23rd Freedom Fund Dinner at Cobo Hall. Doctor McClendon became active in the NAACP in the '30s, serving as president of the national board.

If the citizens of the small farming community of Elsie have anything to say about it, **Doctors Earl Slagh** and **George Bennett** won't be retiring. At 70 and 71, respectively; both have active practices, maintaining not only regular office hours but making housecalls as well. They were featured in a recent edition of *The State Journal*, Lansing. Doctor Slagh and Doctor Bennett have been trying to encourage some young physician to set up a practice in the village to get some help, but their efforts thus far have been in vain. In the meantime, their patients know they can always rely on Doctors Bennett and Slagh to be there when they are needed.

One of Michigan's politically active doctors has moved west with his vigor and vitality still intact. **Leonard Howard, MD,** formerly of Battle Creek, one time board member of MDPAC, doctor-of-the-week, member of the MSMS legislative committee, and otherwise deeply involved in MSMS governmental relations, moved to Hawaii two years ago. Doctor Howard now is speaking for the Hawaii Medical Association in its state's battle over generic vs. brand-name drugs. Doctor Howard's presentation was reported in the March 13 issue of *American Medical News*.

Know what the slow-gait, rack, single foot, and pace are? If not, then ask **Carlton Dettman, MD,** Montrose family physician and expert breeder of American Saddlebred horses. Doctor Dettman has been breeding five-gaited Saddlebreds for 20 years, and during that time has won 24 state championships. Doctor Dettman personally trains, shows, shoes, and even provides some veterinarian needs for his prize-winning horses.

Doctor Cohen

Doctor Dettman

Doctor McClendon

Doctor Turcotte

Margo P. Cohen, MD, Wayne State University Professor of Medicine and Physiology, is recipient of a Probus Club Award for Academic Achievement. In addition to her teaching schedule, Doctor Cohen is chief of the endocrinology and metabolism section at Detroit General Hospital and a consultant in endocrinology at all the Detroit Medical Center hospitals.

Two Michigan physicians have been appointed to committees of the American Medical Association. **Robert B. Carbeck, MD,** Ann Arbor, is chairman of the Advisory Committee on Graduate Medical Education, and **Kenneth J. Ray, MD,** Trenton, is a member of the Ad Hoc Committee on Health Planning.

Charles Krause, MD, Ann Arbor, has been re-elected midwestern regional vice president of the American Academy of Facial Plastic and Reconstructive Surgery, Inc.

Kalyani Misra, MD, has been appointed medical director of the Thumb District Health Department.

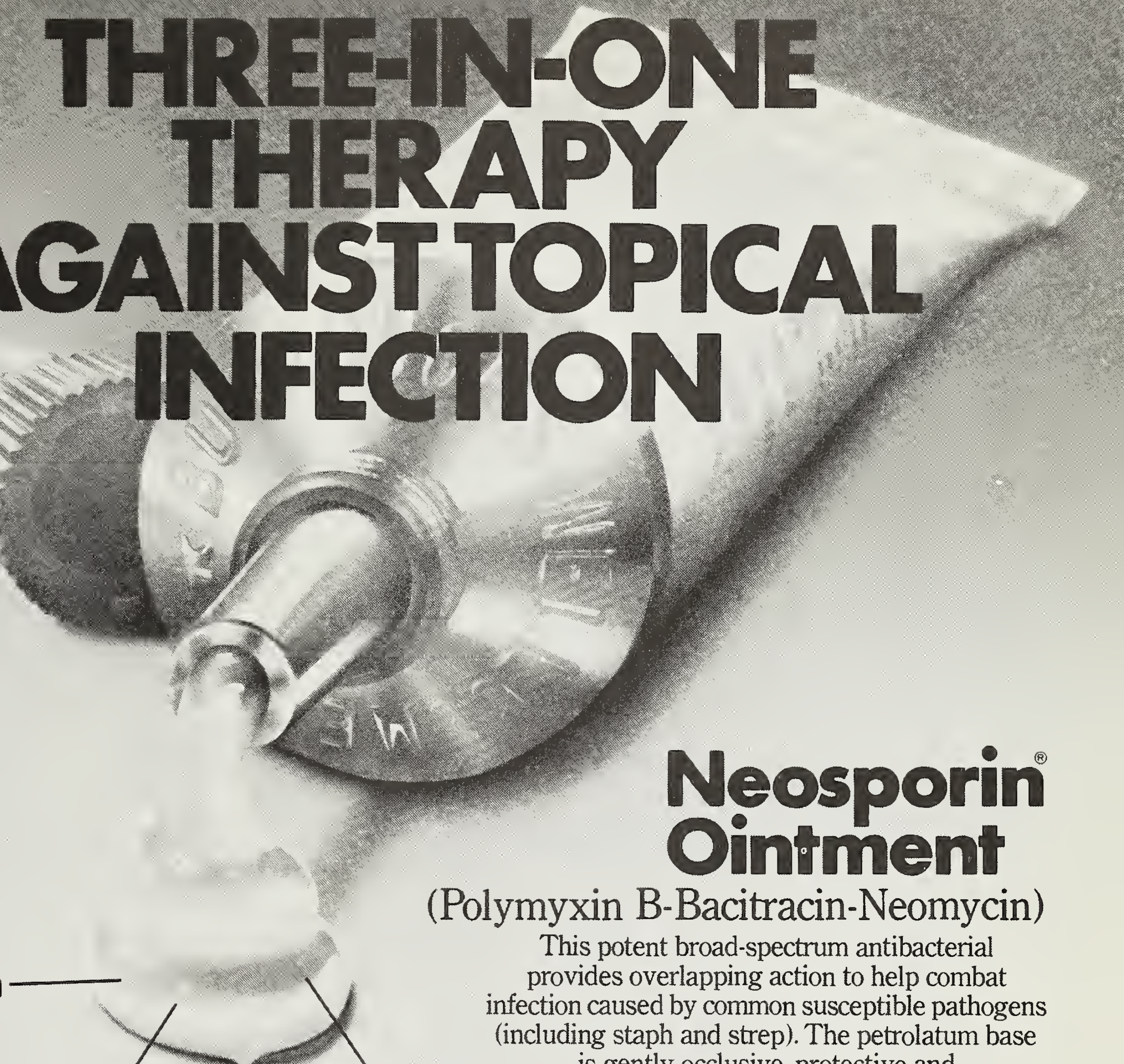
Organizer and administrator for the University of Michigan's new intensified heart disease diagnosis and treatment program is **Bertram Pitt, MD,** a specialist in the detection and treatment of heart disease from John Hopkins University.

The U-M Regents have designated **Jeremiah G. Turcotte, MD,** the Frederick A. Coller Professor of Surgery at the Medical School for a five-year term. Doctor Turcotte has been chairman of the U-M Department of Surgery since 1974.

Named to head the University of Michigan Hospital section on plastic surgery is **William C. Grabb, MD,** who has been acting head of the section since 1975. Doctor Grabb, known for his work in surgical repair of cleft lip and palate, has been on the surgical staffs of the U-M Hospital and St. Joseph Mercy Hospital.

Named director of the Upjohn Center for Clinical Pharmacology at the U-M Medical Center is **Benedict R. Lucchesi, MD,** an authority on drugs which regulate and assist ailing hearts.

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Meetings

(See also listing of Category I programs on page 334).

June 17-22 — AMA Annual Meeting, St. Louis

June 21-23 — "The Elderly with Special Needs: Planning and Programming for the Handicapped," sponsored by Institute of Gerontology, University of Michigan, cost: $85, contact: Jean C. Hamilton, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109.

June 29-30 — "Mental Health in Aging," sponsored by Institute of Gerontology, University of Michigan, cost: $65, contact: Justine Bykowski, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109.

July 10-14 — International Automotive-Medical Meeting, sponsored by the American Association for Automotive Medicine and the International Association for Accident and Traffic Medicine, at the University of Michigan, Ann Arbor, contact: AAAM Secretariat, P.O. Box 222, Morton Grove, IL 60053.

July 10-14 — "Counseling Older Adults and their Families; Principles of Milieu Therapy: Working with the Elderly in Treatment Settings," sponsored by Institute of Gerontology, University of Michigan, cost: $140, contact: Justine Bykowski, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109.

July 8 — MSMS Council, Deer Lake, contact: Warren Tryloff, MSMS director.

July 22-23 — Summer Seminar of the American Association of Medical Assistants, State of Michigan, Schuss Mountain, Mancelona, contact: Helen Schulte, MSMS headquarters.

July 29-Aug. 2 — 32nd Annual Convention and Scientific Assembly, Michigan Academy of Family Physicians, Sugar Loaf Village, Cedar, contact: Rita Feldkamp, 933 Wing St., Plymouth, 48170.

July 31-Aug 4 — "Counseling Older Adults and their Families; Principles of Milieu Therapy: Working with the Elderly in Treatment Settings," sponsored by Institute of Gerontology, University of Michigan, cost: $140, contact: Justine Bykowski, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109.

Aug. 9-11 — "Agency Administration: Fiscal Management; Coping with Changes in the Later Years," sponsored by Institute of Gerontology, University of Michigan, cost: $95, contact: William C. Lawrence, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109.

Aug. 28-Nov. 22 — Fall Medical Review Program for FLEX, ECFMG and VQE, Oakland University, Rochester, cost: $923, contact: Medical Review Program, Center for Health Sciences, Oakland University, Rochester, 48063, 313/377-3563.

Sept. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

Sept. 28-29 — "Agency Administration: Fiscal Management; Coping with Changes in the Later Years," sponsored by Institute of Gerontology, University of Michigan, cost: $65, contact: Mary O'Brien, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109.

Oct. 18-20 — "Medical Education Since 1960 — Marching to a Different Drummer," Michigan State University, sponsored by the W. K. Kellogg Foundation and the Organization of Community-based Medical Schools, contact: Nancy M. Houston, 517/353-0820.

Nov. 1 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

***Nov. 7-9* — MSMS Annual Scientific Meeting, Detroit Plaza Hotel, contact: Herb Auer, MSMS headquarters.**

Dec. 2-6 — AMA House of Delegates Interim Meeting, Chicago.

Dec. 7 — AMA Winter Scientific Meeting, Las Vegas.

Dec. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

MSU medical school paper 'best in country'

Top honors for "best medical school journal in the country" have been awarded to "The Orifice," student journal of Michigan State University's medical complex.

The selection was made by the American Medical Student Association which cited the MSU publication for its "in-depth features, solid news coverage, and overall quality and variety of its editorial impact." Announcement of the award was made at the association's recent annual meeting in Atlanta.

The journal, published two or three times a term as a tabloid newspaper, reports on news, views and activities of 2,200 health science students in MSU's College of Human Medicine, College of Osteopathic Medicine, College of Veterinary Medicine, School of Nursing and School of Medical Technology.

Editor is Pamela Gurnick, second-year MD student in the College of Human Medicine.

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- Eunuchoidism, Eunuchism
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New Double-Blind Study ANDROID-25 vs. Placebo*

*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. Drug Therapy, Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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An MSMS Presidential Citation was presented by Edward Fugate, MD, Muskegon, to Allan W. Bush, left, during the recent MSMS Conference on Medical Aspects of Organized Athletics. Mr. Bush is the retiring head of the Michigan High School Athletic Association and has served for years on the MSMS sports conference planning committee. Doctor Fugate was chairman of the conference.

When Washington comedian and political commentator Mark Russell, seated, spoke at the 1978 MSMS Auxiliary's Legislative Day, MDPAC chairman Thomas Berglund, MD, Kalamazoo, made a special presentation. During luncheon following Mr. Russell's talk, Doctor Berglund pinned a "Yes, there really is a Kalamazoo" button on Mr. Russell.

MSMS photo highlights

Blue Cross/Blue Shield of Michigan and Michigan physicians are hammering out an agreement on ways to hold down the rise in health care costs and ways that the insurance company and physicians can work better together. At a recent meeting between physicians and Blues representatives, the following persons were photographed around the table: Vernon V. Bass, MD, immediate past MSMS president; Daniel J. Kehoe, BCBSM vice president for provider affairs; William Stevenson, BCBSM executive vice president of external affairs; Warren Tryloff, MSMS director; David Siegel, MD, vice chairman, MSMS Council; John B. Bryan, MD, chairman, MSMS committees on socioeconomics, and claims and coding forms; Dean P. Carron, MD, MSMS councilor.

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Deaths

Felix S. Alfenito, MD
Grand Rapids

Felix S. Alfenito, MD, 69, of Grand Rapids, died April 14. Doctor Alfenito graduated from Rush Medical School, University of Chicago. He was on the staff at Blodgett and St. Mary's hospitals, and the board of directors of Michigan Blue Shield. He also served as physician for the Blodgett School of Nursing. Once a delegate to MSMS, Doctor Alfenito was a member of the American Society of Internal Medicine and the Aerospace Medical Association.

Z. Stephen Bohn, MD
Detroit

Z. Stephen Bohn, MD, Detroit, died April 8 at the age of 70. A psychiatrist, Doctor Bohn graduated from the University of Michigan Medical School and the Columbia Presbyterian Neurological Institute. He served as secretary for the Michigan Society of Neurologists and Psychiatrists, and was assistant clinical professor in neurology at Wayne State University School of Medicine.

William R. Flora, MD
Detroit

William R. Flora, MD, a Detroit urologist, died at 76 years of age. Doctor Flora was former medical director of St. Johns Hospital and the president of the staff at Holy Cross Hospital. In addition, he was on the Bon Secours, Cottage and Saratoga staffs. He was a member of the American College of Surgeons and the American Board of Urology.

Martin Z. Feldstein, MD
Southfield

Martin Z. Feldstein, MD, Southfield, died April 8 at 77. A graduate of the University of Michigan Medical School, the surgeon was affiliated with Sinai and Detroit Memorial hospitals, Detroit.

Weldon A. Gift, MD
Sanilac

Weldon A. Gift, MD, of Sanilac County, died Dec. 6, 1977, at the age of 82. A graduate of Jefferson Medical College of Philadelphia, Doctor Gift, a proctologist and surgeon, was affiliated with Marlette Community Hospital. He was a past president of Sanilac County Medical Society and was a fellow of the American Society of Proctology.

Henri L. Gratton, MD
Farmington

Henri L. Gratton, MD, Farmington, died Feb. 27 at 82 years of age. Doctor Gratton graduated from Wayne State University School of Medicine.

Irvine E. Lionel, MD
Sun City Center, FL

Irvine E. Lionel, MD, Sun City Center, FL, died Dec. 12 at the age of 86. A specialist in industrial practice, Doctor Lionel was a graduate of Northwestern University Medical School, Illinois. He was affiliated with General Hospital, Stambaugh, where he was a chief of staff. Doctor Lionel was a past president of the Dickinson-Iron County Medical Society, as well as the U.P. Medical Society. He was a fellow of the Industrial Medical Association.

William C. Kools, MD
Holland

William C. Kools, MD, Holland general practitioner, died May 15 at 83 years. Doctor Kools graduated from Wayne State University School of Medicine and was affiliated with Holland City Hospital, Holland, and Zeeland City Hospital, Zeeland. A past president of the Ottawa County Medical Society, he served as campus physician for Hope College.

John W. Moses, MD
Akron, Ohio

John W. Moses, MD, Akron, Ohio, 56, died April 13. A specialist in internal medicine, Doctor Moses was former director of medical education at Mt. Carmel Mercy Hospital, Detroit. He was also medical director of the physicians assistant program at Mercy College, Detroit. He was affiliated with Harper and Mt. Carmel Mercy hospitals, Detroit; St. Mary's Hospital, Livonia; and the Rehabilitation Institute of Metropolitan Detroit. A graduate of Boston University School of Medicine, Boston, MA, Doctor Moses was a member of the AMA Council on Medical Education, and was an alternate delegate and delegate to AMA from MSMS. He was past president of Wayne County Medical Society and former editor of the *Detroit Medical News* as well as former scientific editor of *Michigan Medicine*.

William D. Peterson, MD
Traverse City

William D. Peterson, MD, Traverse City, died April 4 at age 54. Doctor Peterson received his medical education from the University of Michigan Medical School. He was affiliated with Munson Hospital, Traverse City, and served as director of the Mesick Health Clinic. He was a member of the American Academy of General Practice.

Robert K. Rank, MD
Mt. Pleasant

Robert K. Rank, 54, Mt. Pleasant, died March 7. A pathologist at Central Michigan Community Hospital, Doctor Rank graduated from Hahnemann Medical College of Philadelphia. His memberships in medical organizations include the American Association of Blood Banks, College of American Pathologists, American Association of Clinical Pathologists, and International Pathology Society.

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ORTHOPAEDIC SURGEON needed for Michigan city for modern progressive hospital; expansion underway; near state forests, Lake Michigan; rural setting minutes from major metro areas; recreational opportunities in a 4-seasons setting; excellent salary and fringe benefits. Reply Box 9, MSMS, 120 W. Saginaw, East Lansing, 48823.

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EMERGENCY MEDICAL POSITIONS available with fee-for-service group throughout Michigan, Illinois and other states including all suburban and metropolitan areas. Excellent income opportunity, minimum guarantee provided, malpractice insurance paid. Physician directors also desired. Please send resume to NEEMA Emergency Medical Associates, 500 Spruce Street, Philadelphia, PA 19106. Phone: 215/925-3511.

TWO PEDIATRICIANS needed in growing, young, Dutch community. Excellent opportunity for medical education, recreation and family life. Will help starting physician. Call Grand Rapids, MI, 9 to 11 p.m., 616/531-9803.

FAMILY PRACTITIONER AND/OR PEDIATRICIAN needed in South Haven, a Lake Michigan community. Office suites available in a new professional building adjacent to a well-staffed and expanding community hospital. Call collect and visit South Haven: David Fenske, MD, Office 616/637-5925, Home 616/227-3667.

ONCOLOGIST — A modern, progressive 488-bed hospital located in mid-Michigan has just completed construction of an Oncology Center (Clinac-18 Linear Accelerator and cobalt therapy), and is seeking a board certified or board eligible oncologist. Opportunity is ideal for an individual with experience as a director or assistant director in an established oncology program with an interest in setting up an oncology private practice.

Excellent fringe benefits and the salary is negotiable as is the arrangement for private practice. The position is available immediately. Send curriculum vitae to: Chief of Staff, E.W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, MI 48902 or call 517/487-9183. EOE.

PUBLIC HEALTH PHYSICIAN — $34,994-$45,372. MINIMUM REQUIREMENTS: Possession of a master's degree in public health and a license to practice medicine or osteopathic medicine and surgery in Michigan. Applicant will provide leadership in developing a public health residency program and serve as preceptor for nonprepared physicians entering public health administration. The work will involve working with State and local health departments, hospitals, medical schools and schools of public health. A real opportunity and challenge for one wishing to make an impact upon the future course of public health and preventive medicine.

For further details, please send correspondence and Social Security number to: Public Health Physician-A, P.O. Box 30001, Lansing, MI 48909. AN EQUAL OPPORTUNITY EMPLOYER.

FAMILY PRACTITIONERS, INTERNISTS, and/or OB-GYNs needed in growing, prosperous Dutch community to join a Board Certified family physician in existing practice, or solo available. Excellent economy with medical education, recreational lakes, and ski resorts within 20 mile radius. Will help solo practice to start out. Guarantee net income of $40,000 for first year partner. Call Grand Rapids, MI, 616/531-9803 between 9 and 11 p.m.

GENERAL PRACTITIONER — to provide medical care in a small state hospital for the mentally ill and mentally retarded located in Michigan's beautiful Upper Peninsula. Current salary $37,855 plus a liberal Civil Service benefit package. Write Steven A. Meyers, M.D., Chief of Clinical Affairs, Newberry Regional Mental Health Center, Newberry, MI 49868.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park, there are openings for physicians board qualified as internists, family physicians or psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently over forty thousand per year, plus 23 percent fringe benefits, including life, accident, long term disability, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7789.

MEDICAL DIRECTOR — Full-time position responsibile for providing medical direction, leadership, liaison, and consultation to local health department(s) serving several counties in Michigan's northern lower peninsula. The physician's main office is located in the progressive community of Gaylord which is the center for year-round recreational activities. Position requires Michigan licensure to practice as an M.D. or D.O. and a willingness to participate in preventative and community medicine. Salary is negotiable depending upon experience. To apply or for more information call 616/547-6523, or write: Chairman, Board of Health, District Health Department No. 3, 203 Antrim Street, Charlevoix, MI 49720.

POSITIONS OPEN — New Lake Michigan professional building suites available adjacent to expanding community hospital. Especially desirable for family practitioner, pediatrician and pharmacy. South Haven, Michigan 49090. Call collect: David Fenske, MD, 616/637-5925.

MEDICAL DIRECTOR for 406-bed general hospital, 250 member departmentalized medical staff, five residency programs. Full-time administrative position for physician manager with experience in community hospital medical staff affairs. Interest and knowledge in medical education and quality assurance programs desirable. Area offers a variety of urban-suburban-rural living opportunities in S-E Michigan. Position available July 1, 1978. Send C.V. to Box 5, MSMS, 120 W. Saginaw, East Lansing, MI 48823.

Positions wanted

EXPERIENCED family physician, available for locum tenens work, during the summer, either in busy G.P. practice or Emergency Room. P. J. Greene, MD, 3875 E. Henrietta Road, Henrietta, NY 14467.

GENERAL SURGEON, 40, board certified, peripheral vascular training. Wishes to relocate in Michigan (lower peninsula). Married, one child. References and CV on request. Contact: Rex Williams, MD, 1800 Sullivan #408, Daly City, CA 94015, 415/755-6180.

Miscellaneous

NAPLES, FLORIDA, apartment, 2 bedroom, kitchen, good equipment, pool, nice location. $2,500 winter season (3 to 4 months). Off season $350 to $500/mo. Available any time except December 15 to January 10. Call 203/233-5554.

CAPE COD: FALMOUTH. For sale. Two investment properties. Doctor's five-room suite and handsome wood-shingle seashore residence adjoining. Separate entrances and parking. Scenic wooded area overlooking Woods Hole harbor. Office rental: $4,500. Widow selling. $155,000. Townhouse condominium, two bedrooms. Only 41 units on 25 heavily wooded, rolling acres close to town, beaches and hospital. Private swimming pool, tennis court and clubhouse. Only two years old. Quiet and private location. $55,000. Harold Bach, R.E., 617/540-0707.

Heart Association has booklet for graded exercise testing

The Michigan Heart Association has developed a booklet, "Guidelines for Graded Exercise Testing and Exercise Prescription of Healthy and High Risk Individuals" for use by physicians and other health personnel involved in preventative and rehabilitative exercise programs.

Developed from guidelines set down by the American Heart Association and the American College of Sports Medicine, the booklet includes: definitions of pertinent terms, guidelines for classification of professional personnel, a table of risk factors and predisposing diseases, procedures for graded exercise testing, guidelines for exercise prescription (including task, intensity, duration, frequency and environment) and preventive and rehabilitative exercise programs.

One free copy of the guidelines may be obtained by filling out and returning the coupon below.

Please send me one copy of "Guidelines for Graded Exercise Testing and Exercise Prescription of Health and High Risk Individuals."

NAME ______________________________

ADDRESS ______________________________

CITY ____________________ **STATE** ________ **ZIP** ______

Mail to: Exercise Booklet
Michigan Heart Association
P.O. Box L-V 160
Southfield, Michigan 48076

METAL PLAQUE — Honorary certificates, diplomas, photos, etc. perfectly reproduced in bright silver toned metal with black lettering, all the clarity of the original yet immune to deterioration. Mounted on richly finished walnut base 10 x 12 for only $39.95. Allow four weeks. Perma-Plaque, 553 Lincoln, Grosse Pointe, MI 48230, 313/884-9399.

FOR LEASE: Medical Suite available for lease, 1800 sq. ft. Located on Schoenherr and 11½ Mile Rd., Warren, MI. Close proximity to major hospitals. Call 313-755-1410.

SIX MEDICAL OFFICE SUITES — all new medical center in prime location of Brighton. 1150 square feet to 3000 square feet office units, includes four exam rooms or more, private office and entrance, laboratory, excellent parking, ideal to accomodate one or two doctors. Spring or summer occupancy. Call Davis Professional Bldg., 313/229-2752 or 313/229-7525.

MEDICAL OFFICE SPACES available for lease in a newly built office on Hoover Road between Thirteen and Fourteen Mile Roads in Warren, Michigan. Contact: 939-5830.

FOR SALE — A beautiful, 2600 sq. ft. year-round ranch home on Seaton Creek, Wexford County. Can be purchased with 10 or 50 acres. Close to ski area. Call 616/839-4328. Please ask for Mr. B. Vorsum.

FOR RENT: Reception room, business office, five treatment rooms, lab and restroom. Excellect location. 15 Mile Rd. west of Gratiot, Mt. Clemens, MI. Contact Charles C. Milonas, DDS, 313/791-1600.

President's page

Discovering truth requires perspective

We constantly are challenged to be objective in our observations, attitudes and responses. Is there any such thing as true objectivity? Presumably, the computer could be objective in the evaluation of data. The only problem is that the computer operates as a result of the programs developed by human beings and our biases are included in these programs.

We gather knowledge through experiences we encounter during our lifetimes. We make observations tempered by past experiences. Thus, others may have different combinations of these factors than I and come to quite different "objective" conclusions as a result of their particular experiences. All rational observations, then, are objective but all are equally biased by the limitations of the past upon which these conclusions are drawn.

Milton Sorek, MD, tells the story of his last year as resident in surgery at Detroit General Hospital. Throughout his residency, he had been interested in gall bladder diseases and had accumulated data on the patients with whom he had come in contact.

At a meeting with friends he commented on his concern about the condition. He said he had been doing this study but was not prepared to proceed with an analysis of the data. Among his friends was an actuary who offered to analyze the data for him. His first request, however, was: "Tell me, Milton, in general, what was your impression of what you found. Milton proceeded to relate this.

Some weeks later his friend returned with a set of analyses confirming his impressions beyond his wildest dreams. Milton commented on this and the friend remarked: "Oh, thank you, it was nothing. But, of course, if you want to prove exactly the opposite with the same data, I can do that too."

We are having major differences with economists and administrators in the analysis of data relating to health care. I look at a set of data out of national health statistics and find one set of implications. Others look at the data and come to quite different conclusions.

Louis E. Heideman, MD
MSMS president

Who, in fact, is right? The reality is that probably neither one of us is completely correct. Only as we look at where the other guy is coming from do we come to understand his perspective. Only as we enter with mutual respect into discussions of the data presenting each of our viewpoints can we hope to ultimately come a little bit closer to "truth."

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Division of Hoffmann-La Roche Inc.
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Her next attack of c

the Bactrim™ 3-system counterattack

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resis tant organisms. Thus, Bactrim reduces the risk of introit colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 17 JUNE 16, 1978

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Doctor's countersuit moves along

The Michigan Court of Appeals has reversed a lower court decision and remanded a Michigan physician's countersuit for further proceedings on a malicious prosecution claim. The appeals court concluded there is no legal basis for Seymour Friedman, MD's case on other theories of negligence or abuse of process.

Doctor Friedman now is entitled to try the case on its merits in Circuit Court. The Circuit Court originally dismissed the case (the most prominent of Michigan physicians' countersuit efforts to date) as without legal basis or remedy. The two defendant lawyers may appeal to the Michigan Supreme Court, hoping to sustain the original ruling. Doctor Friedman may wish to attempt the Supreme Court appeal, as the Court of Appeals ruling, while an apparent victory, is on a narrow and difficult technical basis. Malicious prosecution is by far the most difficult of the three theories to prove.

MSMS will monitor the case closely if it goes to the Supreme Court. MSMS legal counsel is mildly optimistic of a broader victory, given the present composition of that Court. MSMS will consider an amicus curiae intervention if the filed briefs of the parties appear to warrant or need such assistance.

(A fuller account of the Appeals Court ruling will appear in a forthcoming Michigan Medicine.)

A. Stewart Kerr
MSMS Legal Counsel

MD/BCBSM work groups tackling rising health care costs

The physician liaison group and the Blue Cross/Blue Shield of Michigan work group will attack the problem of rising health care costs first when they meet again July 11 in renewed efforts to meet the public's concern. That was first priority on the future agenda set by both groups at an organizational meeting June 13 in Detroit. They met to clarify their perceptions of the MD/Blues "agreement" containing four principle objectives adopted in May by the MSMS House of Delegates and the BCBSM board.

The statewide screen for all physicians will go into effect as soon as the joint work group formally adopts a timetable for its plan of work. Meanwhile the Blues' computer is being programmed to implement this decision to be presented to BC/BSM board July 21.

Physician representatives on this project are Donald K. Crandall, MD, Muskegon; John B. Bryan, MD Royal Oak; Frank B. Walker, MD, Detroit; Edward Loniewski, DO, Michigan Association of Osteopathic Physicians and Surgeons

Michigan delegation takes nine resolutions to AMA House

Nine resolutions are being supported by the Michigan delegation at the AMA House of Delegates meeting June 17-21 in St. Louis. The Michigan resolutions resulted from actions of the MSMS House of Delegates May 5-7 in Dearborn. They include action to: oppose extending certificate of need requirements to private physicians offices; ask the AMA to urge government hospitals to take part in cost containment; urge the AMA to work for health education at all grade levels; allow students and house staff to apply associate dues toward their full AMA membership; abolish the Visa Qualifying Exam requirement for FMGs currently licensed to practice in any state and seeking immigration; and urge the AMA Judicial Council to review proposed ethics changes re: solicitation of patients.

CAPSULES

Among the physicians participating in a new MSMS survey, interest is running high for a proposed MSMS pooled trust pension program. Postal cards were mailed to MSMS members May 26, and MSMS has already received about 1700 replies. The MSMS Council authorized the survey to measure interest in this possible new member benefit.

* * *

Michigan Public Health Department Director Maurice A. Reizen, MD, is seeking Michiigan physicians' cooperation in the health survey underway of 6,000 Michigan citizens. The survey is primarily to help assess health risks possibly related to PBB, and is being conducted by the University of Michigan School of Public Health. Letters were sent by Doctor Reizen late in May to all Michigan physicians, describing the survey and asking assistance.

* * *

Start planning now for the 1978 MSMS Annual Scientific Meeting, set Nov. 7-8-9 at the Detroit Plaza Hotel, Renaissance Center, Detroit. First details will appear in the July Michigan Medicine.

Medicaid appropriations bill gains parity with Medicare

Medicaid appropriations for fiscal year 1978-79 have been reported out of the House Appropriations Committee to the House floor and passage by both houses is expected by early July. The measure reflects successful efforts by the MSMS Medicaid Liaison Committee directing the Department of Social Services to "increase screens for all physicians' services provided in an ambulatory setting to current Medicare levels," and additionally, to "increase fee screens for all physicians' services which can only be provided in an inpatient setting to current Medicare levels." The line item for physician services appropriations bill this year is $143,332,000. David Siegel, MD, chairman of the MSMS Medicaid Liasion Committee, who with the Legislature, devised the "medicare parity plan" has been invited to relate the Michigan experience toward the goal of full parity between Medicaid and Medicare screens at a conference of state and local elected officials in Washington, D.C. The "National Symposium on Medicaid " will be held June 21-22 and is sponsored by the Health Care Financing Administration of HEW.

PHSRP in position for final vote after five years of study, action

The massive recodification and renovation of Michigan's public health and health professions' licensure laws have moved into position for final Senate action. Once past the Senate, the bill will return to the House, which either will force it into conference over amendments adopted by the Senate, or accept it with the Senate's 100-plus amendments. Whatever, the basic form of the bill has been cast and few doubt its enactment this year. The project began in 1973, its licensing law changes generally reflect innovations in the Medical Practice Board in its 1973 Rewrite of the Act.

Michigan State Medical Society
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Managing Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS

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CAPSULES

BLUES NEGOTIATIONS--The Michigan physician/Blue Cross Blue Shield of Michigan liaison groups are exchanging position papers on health care cost containment prior to their July 11 meeting in Detroit. The exchange will permit study of each other's ideas with hopes of agreement on a plan of work at the July 11 meeting. The joint efforts follow the MD/Blues agreement forged in May to work together for a better health care system while helping hold down the rise in health care costs.

* * *

JAIL HEALTH--Twenty-five Michigan county sheriffs, jail administrators, jail physicians and nurses are expected at a workshop on improving jail health care delivery planned July 12 at MSMS headquarters. The workshop is part of the county jail health care project funded by the National Law Enforcement Assistance Administration through the AMA. Michigan was one of six states to be involved in the pilot jail health care project. There are now 14 county jails involved with MSMS to achieve AMA accreditation of their jail health systems, and the national project now involves 16 states.

* * *

AMPHETAMINES WAIVERS--The Michigan Medical Practice Board is asking Michigan physicians to recommend what action the Board should take when requests are received for waivers of the rules and regulations on amphetamines' use. The most common diagnosis for which waivers are asked is depression. Physicians with useful comments regarding such waivers are invited to contact the board at P.O. Box 30018, 905 Southland, Lansing, 48909.

Michigan certificate of need resolution adopted by AMA House

Proposals by Michigan physicians were prominent in actions taken by the AMA House of Delegates in annual session June 17-21 in St. Louis, MO. The Michigan delegation to the AMA House introduced nine resolutions in behalf of the MSMS House of Delegates, and most received favorable attention. The MSMS proposal to oppose extending certificates of need to private physicians' offices and a Michigan proposal urging repeal of the Visa Qualifying Exam requirement for FMGs currently licensed to practice were adopted outright by the AMA House. MSMS resolutions to reduce first year dues for new AMA members, to urge review of the Judicial Council's new medical ethics, and to emphasize health education in the school system were woven into alternative resolutions embodying similar proposals from other state delegations. These resolutions then were adopted. A Michigan delegation statement by Brooker Masters, MD, Baldwin, during hearings on cost containment proposals, will be forwarded to the AMA Board of Trustees. MSMS past president Doctor Masters' statement argues that over 50 percent of health care cost escalation is attributable to inflation and government programs and another 25 percent to advanced technology. Doctor Masters declared physicians can have an impact on only 15 percent of the cost rise. The AMA delegates declared their willingness to do whatever they can to help control their portion of the cost rise. Of the 48 recommendations before the House on the AMA-sponsored National Commission on the Cost of Medical Care, 29 were endorsed. Twenty-two, including some endorsed by the House, were referred to the Board of Trustees and two pertaining to peer review and defensive medicine were referred to a special committee on the matter. AM News, June 30-July 7, will carry specific action on each of the commission recommendations. Thomas R. Berglund, MD, Kalamazoo, and Donald K. Crandall, MD, Muskegon, served on reference committees of the House. Chairman of the Michigan delegation, Robert E. Rice, MD, Greenville, will report to The MSMS Council July 8.

CAPSULES/continued

MALPRACTICE SHOW--A malpractice update with MSMS Councilor Adam C. McClay, MD, Traverse City, is scheduled to be broadcast at 6 p.m. Sunday, July 16, by Cadillac's WWT-TV, Channels 9/10. The update will be featured on the regular program, "Eye on Michigan," and includes segments with Merwyn G. Scholten, MSMS media relations specialist.

* * *

HOSPITAL-BASED SPECIALISTS--Representatives of the Michigan Radiological Society and the Michigan Society of Pathologists have begun regular attendance at meetings of the Plan and Policy Development Committee of the Statewide Health Coordinating Council. Their attendance has been coordinated by MSMS following proposals for the state health plan to eliminate fee-for-service for hospital-based radiologists and pathologists. The Plan and Policy Development Committee adopted a motion on June 14 directing the Office of Health and Medical Affairs to work with other groups, including radiologists and pathologists, to explore the utilization and price-per-unit issues.

Scientific Meeting plans advance

Sixty half-day Category I courses will be offered to MSMS members attending the 1978 MSMS Annual Scientific Meeting Nov. 7-8-9 at the Detroit Plaza Hotel in the Detroit Renaissance Center. First details will appear in the July issue of Michigan Medicine. A monthly newsletter about the Scientific Meeting is being mailed to course directors, MSMS Council members and specialty society members. Course information is available from Herbert Auer and Sherry Fent of the MSMS Division of Public Service, Communication and Physician Education.

New public health code goes to governor for signing

The new Public Health Code, conceived during the 1973 centennial of the Department of Public Health, finally was enacted by the Legislature in the last days of the spring session. Often amended and more often defended from amendments, the 457-page bill reached final agreement and was sent to the Governor for signature. Much of the Legislation contains updated language of existing statues, such as the organization of the Department of Public Health, the collection and storage of research data, governance of fluoride programs, food sanitation and health maintenance organizations. Major changes of significance to physicians are the creation of a Health Occupations Council as an advisory umbrella group over health licensing boards; alterations in the state certificate of need law that requires CON for "tertiary health care facilities"; a hospital bed reduction plan intended to eliminate excess hospital beds in Michigan, and a declaration of basic health services required by every individual. A complete review and analysis of PHSRP will be published in the August Michigan Medicine.

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MSMS SCIENTIFIC MEETING COURSE LIST INSIDE

"MSMS members should study the extensive list on pages two and three of the 57 Category I courses arranged already for the 1978 MSMS Annual Scientific Meeting, Nov. 7-8-9 at the spectacular Detroit Plaza Hotel."

That suggestion is made by Carl F. Hammerstrom, MD, chairman, MSMS Committee for CME Programming and Robert F. Wilson, MD, Annual Scientific Meeting chairman.

"Please read the list of practical courses and block out Nov. 7-8-9 on your appointment calendar," they advise.

Further details and a registration form will appear in an early September Medigram.

Leaders expect 1,500 physicians to enroll and earn Category I credits required for state relicensure.

The MSMS Council has set the tuition for MSMS members at $4 per credit hour or $12 for a half-day, three-hour course. House officers will be permitted to attend free of charge.

Non-member physicians will be charged $8 per credit hour. Tuition and exhibit income will cover the cash outlays for speakers' honoraria and expenses, postage, printing, coffee breaks, audio visuals and other operational expenses. The total budget is $60,778, not including the $30,000 contributed by the MSMS budget to cover time devoted by staff members.

Highlights of July 8 MSMS Council meeting

At its midsummer meeting July 8 at Boyne Mountain, The MSMS Council:

1) Approved adoption of a pooled pension trust program for the investment and administration of MSMS members' contributions to Keogh and PC plans. The Council authorized the necessary funds and staff support to create the trust. (See related article on back page.)

2) Approved sending a letter to Blue Cross/Blue Shield of Michigan informing BCBSM that MSMS is aware of BCBSM efforts to meet with medical staffs and component societies requesting their input prior to auto company contract negotiations. MSMS already has begun organizing physician input to the auto contract talks, after the Blues agreed MSMS would serve as a focal point and work with the Council of Specialty Societies to coordinate the suggestions of the specialties as well as individual MSMS members. Individual members are urged to participate through their specialty societies or write to MSMS President Louis E. Heideman, MD, at MSMS headquarters.

3) Received for information a report that the Department of Social Services is going to participate in a voluntary BCBSM survey on second surgical opinions. The Blues have money from HEW for a study of Medicare patients' surgery and have invited the DSS to consider using the study for Medicaid.

4) Approved charging $4 per credit hour to members attending the MSMS Annual Scientific Meeting in November and $8 per credit hour to non-members. A full ASM budget of $60,778 was approved.

5) Approved having staff explore the possibility of a Michigan foundation funding an extensive research project on the rise in overhead costs of medical practice and study of each component of the costs of medical practice.

6) Sent back to the Task Force on Medical Care Costs Practical Guides 3 and 4, on Discharge Planning and Outpatient Surgery, respectively. The guides, when completed, are to be sent to medical staffs to help them in developing cost containment strategies and programs. The Council asked the Task Force for further work on both guidelines.

1978 MSMS Annual Scientific Meeting Offers 57 Courses at Detroit Plaza

All Courses will be for three hours of Category I credit.

November 7

Tuesday Morning (8:30 to Noon)

☐ "Newer Developments in the Evaluation and Treatment of the Hypertensive Patient." *Director: Charles P. Lucas, MD, Department of Internal Medicine, Wayne State University School of Medicine.*

☐ "Management of Diabetes Mellitus — Problems in Acute and Chronic Care." *Director: Sumer Pek, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "Sex and the Heart Patient." *Director: Mario Petrini, MD, Department of Obstetrics and Gynecology, Wayne State University School of Medicine.*

☐ "It's Now Easy to Recognize & Manage Chronic Obstructive Pulmonary Disease." *Director: John G. Weg, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "What's New and Practical in Peripheral Vascular Surgery." *Director: James C. Stanley, MD, Department of Surgery, University of Michigan Medical School.*

☐ "Basic Cardiac Life Support." *Director: Dan Anbe, MD, Department of Cardiovascular Medicine, Henry Ford Hospital.*

☐ "Common Pitfalls in the Management of Malignancies." *Director: Vainutis K. Vaitkevicius, MD, Department of Oncology, Wayne State University School of Medicine.*

Tuesday Afternoon (1:30 to 5:00)

☐ "What's New in Anti-Arthritics, Beta-Blockers, Bronchodilators, Vasodilators — With Special Attention to New Agents and Drug Interactions." *Director: George L. Royer, Jr., MD, Kalamazoo, for MSMS Section on Clinical Pharmacology.*

☐ "Alcohol and Medical Practice." *Director: Russell F. Smith, MD, Brighton, for MSMS Committee to Assist Impaired Physicians. Sponsored also by Michigan Psychiatric Society, Michigan Chapter of American Geriatrics Society, and Michigan Chapter of American Medical Society on Alcoholism.*

☐ "Care in the September Years." *Director: Edward Cotton, MD, Kalamazoo, Sponsored by Michigan Academy of Family Physicians.*

☐ "Assessment and Management of the Patient with Acute and Chronic Renal Failure." *Director: Gilbert H. Mayor, MD, Department of Internal Medicine, Michigan State University College of Human Medicine.*

☐ "Sexuality: New Recognition Or Another Perspective of an Old Subject." *Director: Charles J. Danek, MD, Department of Physical Medicine and Rehabilitation, University Hospital, Ann Arbor. Sponsored by Michigan Society of Physical Medicine and Rehabilitation.*

☐ "Current Trends in Coronary Artery Bypass Graft Surgery." *Director: Bertram Pitt, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "What's New and Practical in Office Endocrinology." *Director: Subhash Gulati, MD, Department of Internal Medicine, Wayne State University School of Medicine.*

* * *

57th Annual Beaumont Lecture, Tuesday Evening, November 7, 1978. Sponsored by Wayne County Medical Society

☐ "Current Trends in Gastroenterology." *Director: Howard M. Spiro, MD, Section of Gastroenterology, Yale University School of Medicine.*

November 8

Wednesday Morning (8:30 to Noon)

☐ "Newer Developments in Diagnosis and Treatment of Neurovascular Problems." *Director: John Gilroy, MD, Department of Neurology, Wayne State University School of Medicine.*

☐ "Office Gynecology for Non-Gynecologists." *Director: R. Ralph Margulis, MD, Department of Obstetrics-Gynecology, Wayne State University School of Medicine.*

☐ "Diagnosis & Treatment of Common Esophageal Disorders." *Director: Mark B. Orringer, MD, Section of Thoracic Surgery, University of Michigan Medical School.*

☐ "Office Dermatology for the Non-Dermatologist." *Director: Thomas F. Downham, II, MD, Department of Dermatology, Wayne State University School of Medicine. Sponsored by Michigan Dermatological Society.*

☐ "Dizzy Patient — An Otologic Review for the Generalist." *Director: Eugene Rontal, MD, Department of Otolaryngology, Wayne State University School of Medicine.*

☐ "Diagnosis and Treatment of the Hermatological Patient." *Director: Carter Bishop, MD, Department of Internal Medicine, Wayne State University School of Medicine.*

☐ "Common Errors in Pediatric Management." *Director: Ralph Cash, MD, Department of Pediatrics, Wayne State University School of Medicine.*

☐ What's New in Surgery." *Director: Dan C. English, MD, Department of Surgery, Michigan State University College of Human Medicine.*

☐ "Lead Poisoning — An Update." *Director: William L. Knapp, MD, Chrysler Corporation. Sponsored by Michigan Occupational Medicine Association.*

☐ "Pneumonia." *Director: Kenneth R. Wilcox, MD, Lansing, Michigan Department of Public Health.*

☐ "Advanced Cardiac Life Support." (A 12-Hour Course to run all day Wednesday and Thursday.) *Director: Dan Anbe, MD, Department of Cardiovascular Medicine, Henry Ford Hospital.*

☐ "New Concepts in Peptic Ulcer Disease / New Approaches to Obstructive Jaundice." *Director: John P. Papp, MD, Grand Rapids. Sponsored by Michigan Society for Gastrointestinal Endoscopy.*

Wednesday Afternoon (1:30 to 5:00)

☐ "Identification and Management of the High-Risk Obstetrical Patient." *Director: Charles W. Aldridge, Jr., MD, Grand Rapids. Sponsored by Michigan Society of Obstetricians and Gynecologists.*

☐ "Diagnosis and Management of Bronchial Asthma in Children." *Director: John A. Anderson, MD, Henry Ford Hospital, Detroit.*

☐ "Diagnosis and Treatment of Common Rheumatic Disorders." *Director: Giles G. Bole, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "Cutaneous Manifestations of Systemic Disease." *Director: Thomas F. Downham, II, MD, Department of Dermatology, Wayne State University School of Medicine. Sponsored by Michigan Dermatological Society.*

☐ "Current Concepts and Management of Common Pediatric Surgical Problems." *Director: Jack H. Hertzler, MD, Department of Surgery, Children's Hospital, Detroit.*

☐ "Congestive Heart Failure — New Concepts in Evaluation and Therapy." *Director: Bertram Pitt, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "Approach to Chronic Intractable Pain." *Director: James Taren, MD, Neuro Behavioral Science, University of Michigan Medical School.*

☐ "Dealing With Women Patients." *Director: Linda Logsdon, MD, Southfield.*

☐ "Male Sexual Problems: Impotency, Infertility." *Director: Gerald F. Conway, MD, Royal Oak. Sponsored by Michigan Branch, American Urological Association.*

☐ "Nuclear Medicine — Review of Current Applications and New Developments." *Director: Daniel S. Marks, MD, Detroit. Sponsored by Michigan College of Nuclear Medicine Physicians.*

☐ "Emergency Care." *Director: Ronald L. Krome, MD, Detroit. Sponsored by Michigan Chapter, American College of Emergency Physicians.*

☐ "Medical Care Cost Awareness." *Director: Charles R. Zimont, MD, Constantine, MSMS Committee on Medical Care Costs.*

November 9

Thursday Morning (8:30 to Noon)

☐ "Role of Hyperalimentation in Common Medical and Surgical Disorders." *Director: Richard E. Dean, MD, Grand Rapids, Michigan State University College of Human Medicine.*

☐ "Exercise in Medicine: Controversies, Indications, Proper Prescribing, and Precautions." Co-Directors: *Joseph Arends, MD, Troy, Wayne State University Department of Family Medicine and Fred Stransky, PhD, Rochester, Oakland University Department of Physical Education.*

☐ "Antibiotics." *Director: A. Martin Lerner, MD, Department of Internal Medicine, Wayne State University School of Medicine.*

☐ "Transplantation: Current Status and Involvement of All Specialties." *Director: Jeremiah G. Turcotte, MD, Department of Surgery, University of Michigan Medical School.*

☐ "Frequent Problems in ECG Interpretation." *Director: Franklin E. Hull, MD, Department of Medicine, Wayne State University School of Medicine.*

☐ "Scientific Medical Writing." *Director: Archie Bedell, MD, Grosse Pointe. Sponsored by Michigan Chapter, American Medical Writers Association.*

☐ "Diagnosis and Treatment of Common Athletic Injuries." *Director: Gerald A. O'Connor, MD, Ann Arbor. Sponsored by MSMS Committee on Medical Aspects of Organized Athletics.*

☐ "Immunology and Inflammatory Bowel Disease." *Director: Manuel Sklar, MD, Detroit. Sponsored by the National Foundation Ileitis and Colitis.*

☐ "Diuretic Therapy: Applications and Complications." *Director: Richard L. Tannen, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "Interpreting the Biochemical Profile." *Director: Kenneth A. Greenawald, MD, Department of Pathology, Henry Ford Hospital.*

Thursday Afternoon (1:30 to 5:00)

☐ "Medical Genetics for the Practicing Physician." *Director: Thomas D. Gelehrter, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "Chronic Non-Alcoholic Liver Disease." *Director: Keith S. Henley, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "What's New in Acid-Base and Fluid-Electrolyte Balance." *Director: Franklin D. McDonald, MD, Department of Medicine, Wayne State University School of Medicine.*

☐ "What's New and Practical in the Retina." *Director: Carole West, MD, Grosse Pointe Park. Sponsored by Michigan Ophthalmological Society.*

☐ "Antibiotic Therapy — New Advances." *Director: Carol A. Kauffman, MD, Ann Arbor, University of Michigan Medical Center.*

☐ "Panoramic View of Marital Therapy." *Director: Peter A. Martin, MD, Southfield. Sponsored by Michigan Psychiatric Society.*

☐ "Diagnosis and Treatment of Cardiac Arrhythmias." *Director: Franklin E. Hull, MD, Department of Medicine, Wayne State University School of Medicine.*

☐ "Common Problems in Thoracic Surgery." *Director: Raymond J. Barrett, MD, Detroit. Sponsored by Michigan Society of Thoracic Surgeons.*

☐ "What's New in Radiology." *Director: Kenneth Krabbenhoft, MD, Detroit, Department of Radiology, Wayne State University School of Medicine.*

CAPSULES

COLLER-PENBERTHY-THIRLBY--Northern Michigan physicians will gather at the Park Place Motor Inn, Traverse City July 27-28 for the annual Coller-Penberthy-Thirlby Medical Conference. A wide variety of courses will be presented to the physicians, who can earn a total of 9 Category I credit hours by attending. Speakers will come from all three Michigan medical schools, as well as the University of Cincinnati, University of Texas, Baylor College and Johns Hopkins. Registration is $25 and can be made with Thomas C. Auer, MD, Thirlby Clinic, Traverse City, 49684. General chairman is Kenneth H. Musson, MD, Traverse City.

* * *

WATCH FOR CME FOLDER--A convenient folder for CME recordkeeping will be inserted in the next issue of the Medigram, which should go in the mail approximately July 26. The folder will answer common questions about the CME reporting law, and include charts for handy reference to a physician's accumulated Category I-VI hours. Verification of attendance at each CME course can be kept inside the folder. Be sure to watch for it in the next Medigram.

MSMS Council approves physician pension plan

MSMS members soon will have the opportunity to invest in their own retirement savings program. The MSMS Council July 8 approved an MSMS pooled trust pension program. A team of experts is being formed to draw up the MSMS pension program, which physician with Keogh or professional corporation retirement plans could join. The team will include a pension consultant, investment banker, investment monitoring service and legal counsel. The Council approved the MSMS pooled pension plan after an MSMS membership survey, just completed, showed that 64 percent of the respondents already with Keogh or PC retirement programs would switch to an MSMS program, that 65 percent of MSMS members with no current retirement program would join an MSMS program, and that 84 percent of all respondents said MSMS should develop a pension plan as a member benefit. Greater details will follow in Michigan Medicine and Medigram.

Medicaid appropriations bill gains parity with Medicare

Another step toward total equity between Medicaid and Medicare reimbursement was taken with final Legislative action on the Department of Social Services state appropriations bill. In 1977, MSMS, with legislative leaders and the Department of Social Services, achieved parity with Medicaid reimbursements for ambulatory services; this year the equity issue was pushed for inpatient services, also Final language in the 1978 appropriations bill calls for Medicare-equivalent fee screens for all physicians' services provided on an outpatient basis and for services which can only be provided in an inpatient setting. This new language is designed to encourage outpatient services whenever hospitalization can be avoided.

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MICHIGAN MEDICINE

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

Michigan Medicine

The vital links between mother and baby are the subject of study by the MSMS Committee on Maternal and Perinatal Health, topic of this month's special section. (Photo by Mert Scholten, MSMS staff.)

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The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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Healthy mother and baby goal of MSMS Maternal/Perinatal Committee

By Lee B. Stevenson, MD
Farmington Hills

These four pages constitute a special section on the work of the MSMS Committee on Maternal and Perinatal Health and its 10 subcommittees.

The focus on maternal and perinatal health is not as morbid as the accompanying articles suggest, although we can always learn from the errors in some of the maternal mortality studies. The tissue registries based at the University of Michigan and Michigan State University are tissue storehouses for research and several articles have been based on these data.

The goal of obstetrics is a healthy mother and product of her pregnancy. The committee has not confined itself to this with recent efforts emulating a Minnesota study of deaths from cervical cancer. At the present time, the continuation of the study is stymied by a need for funding.

Doctor Stevenson is chairman of the MSMS Committee on Maternal and Perinatal Health.

More direct activities include research and discussion of:

1. nutrition in pregnancies;
2. obstetrical and neonatal planning (formerly called "better utilization of obstetric beds");
3. home deliveries and alternatives;
4. PCS record forms or alternatives for standardization of obstetric and neonatal record keeping;
5. review of perinatal data of morbidity and mortality in Michigan;
6. collection and evaluation of data on maternal deaths in Michigan since 1949;
7. quarterly review of data from the Maternal and Placental Tissue Registries.

Educational output from the committee takes many forms. The 17th Annual Michigan Conference on Maternal and Perinatal Health was held in March at the Hyatt Regency in Dearborn with professional stars from around the country to educate physicians, nurses, and students. The success and popularity of this conference is measured by its attendance, near 1,000 each year, and the widely varied sponsorship. Besides the Michigan State Medical Society and the Michigan Department of Public Health, specialty organizations representing gynecologists/obstetricians, pediatricians, perinatologists, neonatologists, obstetric and pediatric nurses, and many ethical pharmaceutical houses have supported the program over the years.

Further education is enjoyed in the informal two-day retreat to the Michigan State University Conference Center at Gull Lake each year. The wholesome shirt-sleeve atmosphere is punctuated by many voices and opinions as everyone has a chance for active participation.

From the committee comes the writing, publication and dissemination of desk reference cards on subjects of concern to physicians, nurses, and our patients. These provide quick, concise access to lifesaving information if kept handy in the office or delivery suite in the hospital.

Much of the success and popularity of the committee is its broad base of involvement with physicians from private practice, group practice, medical school teachers, the Michigan Department of Public Health — mostly leaders in our state with a statewide geographic spread. Specialists in gynecology/obstetrics, perinatology, neonatology, pathology, family practice, anesthesiology, public health, health care facilities, hospital administration, osteopathic medicine, and staff liaison with MSMS with Helen Schulte as secretary to the committee, and Herb Auer working on the Maternal and Perinatal Health Conferences — ALL are one big, happy family striving to improve the lot of women and children in Michigan and around the world.

On behalf of the committee and its dedicated staffers we invite you to read further in this special section and hope you enjoy this deeper look into one of MSMS's most active committees.

Placental tissue registry important to health of future mothers and infants

By Charles H. Sander, MD
East Lansing

The Michigan Placental Tissue Registry was initiated in 1970, as a subcommittee of the MSMS Committee on Maternal and Perinatal Health. Its founder was the late Joseph R. Cipparone, MD, pathologist at St. Lawrence Hospital, Lansing, who established the registry in the Michigan State University Pathology Department. Doctor Cipparone was the registry's first director.

A summary of the first 500 cases was prepared by Doctor Cipparone before his untimely death in 1975. This was presented by Lawrence Nathan, DO, at the University of Michigan in June, 1975, at a postgraduate seminar sponsored by the U-M Department of Pathology.

The registry now has collected approximately 1,000 cases. The registry is sponsored by the Michigan Department of Public Health through the MSMS and its Committee on Maternal and Perinatal Health.

The purpose of the registry is the acquisition of pathologic placental specimens, which are contributed from various sources in Michigan. Knowledge gained by the study of these specimens is disseminated to those concerned with the care of the pregnant patient and her child. Any physician in the state of Michigan is welcome to send a placental specimen to the registry without cost. Specimens most appropriate to such examination are those associated with habitual abortion, congenital anomalies, placental anomalies, multiple births, disease conditions or exposure occurring during pregnancy, and stillbirths. Specimens are processed at the registry in the Department of Pathology at Michigan State University, and reports are sent back to the physicians concerned.

Considerable material now is available for study within the registry.

Some special projects under consideration are those involving infectious disease, which comprises a large portion of the lesions seen and diagnosed. Approximately 15 to 20 percent of cases reveal a lesion referred to as chronic fibrosing villitis. This lesion has been associated with certain viral infections such as: cytomegalic inclusion disease, rubella and herpes. In additon, toxoplasmosis may produce a similar lesion, as may syphilitic involvement of the placenta. Work is in progress to more completely describe this lesion, particularly from the immunological, as well as structural affects on the placenta.

Workers at the registry are planning a long term follow-up in patients whose placenta revealed this lesion, to correlate clinical abnormalities in the affected infants and/or children. It is anticipated that clinical follow-up originating from the registry will contribute valuable, correlative information concerning other disease processes which are prevalent — namely diabetes, pre-eclampsia, toxemia, erythroblastosis and structural abnormalities of the placenta, such as marginal or velamentous cord insertion, absence of one umbilical artery, amnion nodosum and other types of infectious conditions. Considerable interest also exists at the registry regarding the affects on the placenta of exposure to toxic substances during pregnancy such as PBB, alcohol, cigarette smoke and other environmental pollutants. The registry is collaborating with the long-term PBB study of the Michigan Department of Public Health. Placentas from contaminated areas are being sent to the registry.

The registry not only serves as a valuable resource in collecting research data, but also gives direct information to the physician, which may have an important bearing on the health of the mother and infant, or the well-being of a future pregnancy. Examples of this include the discovery of unsuspected fetal-maternal isoimmunization, unsuspected maternal hypertension or pre-eclampsia, maternal diabetes and maternal-placental-fetal infectious disease, to name a few. The registry encourages the continuing support of physicians throughout the state of Michigan to use its facilities by sending material for diagnosis and consultation. We at the registry express our gratitude to the Michigan Department of Health and the Michigan State Medical Society for their support of the registry and its activities.

The baby on the cover is Frances Katherine Fent, six month-old daughter of MSMS staffer Sherry L. Fent and husband James Kim Fent.

Doctor Sander is director of the Placental Tissue Registry and chairman of the MSMS Placental Tissue Registry Subcommittee.

MSMS subcommittee promoting regionalized perinatal care in Michigan

By James R. Irwin, MD
Grand Rapids

Activities and accomplishments of the Subcommittee on Obstetrical and Neonatal Planning* last were reported in *Michigan Medicine* in March 1973. At that time the subcommittee efforts were cooperating with the Michigan Department of Public Health and others to revise State licensure standards for hospital obstetrical departments; to develop and publish "Guidelines for Hospital Obstetrical Departments and Newborn Nurseries"; to assist in the evaluation of requests from individual hospitals for permission to utilize surplus obstetrical beds for clean gynecological patients; and to continue efforts to eliminate duplicative and/or substandard hospital obstetrical departments throughout the state.

More recently, the subcommittee primarily has been promoting and implementing the concept of regionalized perinatal care in cooperation with the Department of Public Health, the Perinatal Association of Michigan and others. The importance of a regionalized system of perinatal care has been broadly recognized not only in Michigan but in other states as well. The concept is most adequately described in the document "Toward Improving the Outcome of Pregnancy" published in 1976 by the Committee on Perinatal Health and the National Foundation — March of Dimes. The Committee on Perinatal Health included representatives from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists and the American Medical Association.

Perinatal care includes the care of the mother, the fetus and the newborn infant. Perinatal care must assure a full spectrum of inpatient and outpatient services as well as community outreach; professional and lay education; transport services; and provisions for the monitoring of quality and utilization of perinatal care in a given region.

The above document lists perinatal care programs and facilities on three levels:

Level I programs and hospitals provide services primarily for uncomplicated maternity and newborn patients. Emphasis is given to the recognition of potential or actual maternal-fetal and neonatal complications with early and appropriate referral to either Level II or Level III programs and facilities.

Level II programs and hospitals are generally located in the larger urban and suburban areas where the majority of deliveries occur. Such programs and facilities provide a full range of maternal-fetal and neonatal services for uncomplicated patients and for the majority of patients with complicated obstetrical problems and certain neonatal illnesses. They usually have a highly trained multidisciplinary staff and modern, well maintained facilities and equipment. A few mothers with severe obstetrical complications and some seriously ill newborn infants will require transfer to a Level III program and facility.

Level III programs and hospitals provide services for the full range of maternal-fetal and newborn patients including care for the most serious types of maternal-fetal and neonatal illnesses and abnormalities.

Level III programs and hospitals serve as regional centers. Through their physicians and staff they are responsible, in addition to the care and services described above, for coordinating available resources within the region so that they are effectively and efficiently utilized; providing educational programs for physicians, nurses, paramedical personnel and the general public; community outreach services; transport services; and monitoring of the quality and utilization of perinatal care in the region.

It is the stated objective of the subcommittee that a Level II program and hospital should be made available wherever possible to every expectant mother and her newborn infant. In rural areas or where unique geographic barriers to accessibility exist, a Level I program and hospital may be justified to meet the needs of the service area population.

Regional centers have been identified and designated by the department of public health and regional planning agencies. In a few regions, perinatal programs are reasonably well developed and implemented. Unfortunately, much remains to be done in most regions, particularly with respect to community outreach, education, transport services and monitoring of care.

Subcommittee efforts in the next few years will be directed primarily to further developing and implementing this desirable care concept. Obviously, this will entail a great deal of time and effort on the part of subcommittee members to meet with regional planning agencies, hospital administrators and directors of perinatal care programs.

Doctor Irwin is chairman of the subcommittee on Obstetrical and Neonatal Planning.

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*Formerly the Subcommittee on Better Utilization of Obstetrical Beds

Maternal tissue registry vital link between obstetricians and pathologists

By Ronald Nishiyama, MD
Ann Arbor

Twenty-two years ago the Michigan State Medical Society Maternal Health Committee, the Michigan Department of Health, the Michigan Society of Obstetricians and Gynecologists, and Michigan Society of Pathologists agreed to sponsor the establishment of a Registry of Maternal Tissues. The Michigan Association of Osteopathic Physicians and Surgeons also support the registry.

The registry is housed in the Department of Pathology, The University of Michigan Medical Center.

The purposes of the registry are:

(1) To collect, diagnose, and study the tissues submitted from cases of maternal death in Michigan upon whom necropsies have been performed;

(2) To analyze and correlate the verified pathologic diagnoses with the clinical data so cases of maternal death can be more accurately measured;

(3) To supply pathologic material to qualified residents and physicians for professional education;

(4) To stimulate interest in securing more necropsies in cases of maternal death;

(5) To report regularly to the Maternal Health Committee, Michigan State Medical Society.

The Michigan Maternal Registry is unique. It may be the only one in existence in the United States. To date, there are 668 cases in the registry. The collection of autopsies in a central repository has allowed the development of expertise in the evaluation of the causes of maternal deaths and the pathologic changes that may be peculiar to such deaths.

The registry has grown not only in number but has developed into a valuable tool which is regularly utilized by the Committee on Maternal Health of the Michigan State Medical Society to evaluate the causes of maternal deaths.

The value of autopsies in assessing the causes of death during or after pregnancy has been repeatedly emphasized. This is illustrated by two cases. One was that of a 40-year-old woman who died two-and-a-half weeks post-partum and the second was a 36-year-old woman who collapsed and died 19 days post-partum. Both patients died of dissecting aneurysms of the coronary arteries. Obscure causes of death in the normal population, but not rare among post-partum women. There are four cases of deaths from dissecting aneurysms of the coronary arteries in the registry.

The evolution of the role of the pathologist in aiding and evaluating maternal deaths has been one of the unforeseen dividends that has accrued from the establishment of the registry.

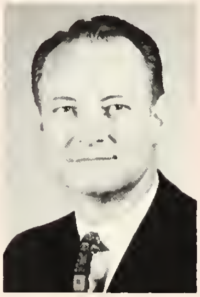
One member of the Department of Pathology, University of Michigan Medical Center, has been in charge of the registry for 14 years. He also serves with the Sub-committee on Maternal Deaths. Thus, the pathologist has ceased to be a passive observer and has become an active participant, a role which probably should be developed in other committees throughout the United States that serve the same function.

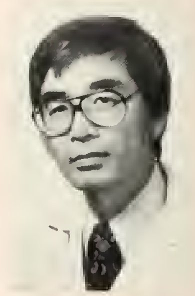
The Maternal Tissue Registry has matured from a simple repository into a vital link in communication between obstetricians and pathologists. One that has been, and shall continue to be, of mutual benefit.

Four publications have been written utilizing data obtained from the registry.

Doctor Nishiyama is head of the Michigan Registry of Maternal Tissues and is a member of the MSMS subcommitte on Maternal Deaths.

Contributors to this special section:


Doctor Stevenson


Doctor Nishiyama

Doctor Sander

Doctor Irwin

Liability

Here are Michigan laws regarding treatment of minors in regular, emergency cases

This information is advisory only and is *not* intended to imply or establish a standard of care, or to substitute for advice of personal legal counsel.

Physicians who treat minors without parental consent have been sued for assault, technical battery and even abridgment of property rights. The point is this: even when the care is appropriate, you can be sued if you fail to obtain the parent's permission.

A minor is defined as a person under age 18. There is no rule laid down in Michigan except the general rule that medical treatment of minors requires the consent of parent or guardian except in emergency. As you know, treatment without consent is assault and battery. A girl is now an adult at 18 but such things as marriage or emancipation enter into the problem of adulthood and enter into the question of informed consent.

VD drug use

Also, parental consent is not required to treat or counsel minors age 12 or older if they use depressant or stimulant drugs or have contracted venereal disease. In these cases, you are not even obligated to inform the parents that you are providing care.

In matters of prescribing birth control pills, a child under the statutory age is not likely to have, at law, sufficient mental capacity or independance from her parents to give a valid consent. Moreover, when the parents discover the child has been given the pill, they could involve the doctor in a charge of contributing to the delinquency of a minor. The prudent practice is to get parental consent. MSMS legal counsel believes it to be the legal test as well.

Married minors

The instance of the married 16-year-old girl is troublesome. Michigan law releases legally married minors from parental control but apparently it is still true that girls 16 to 18 need parental consent for marriage. Before dispensing pills to married girls under 18, parental consent and the husband's consent, prudently, should be obtained.

(This is the seventh in a series of articles on risk management to appear in Michigan Medicine. It is sponsored by the MSMS Committee on Professional Liability, chaired by Robert M. Leitch, MD, Battle Creek, MSMS secretary. The material was originated with the Illinois State Medical Society and has been adapted to fit Michigan laws. The MSMS has prepared tapes on the subject.)

The law grants wide latitude in emergency situations. You can render emergency care without parental consent if you believe waiting for that permission is not feasible and would adversely affect the minor's health. In fact, if the situation is serious, you may face a greater liability by delaying treatment. However, document your attempt to contact the parents. If you know the parents would not consent to a blood transfusion because of religious beliefs, you must obtain a court order.

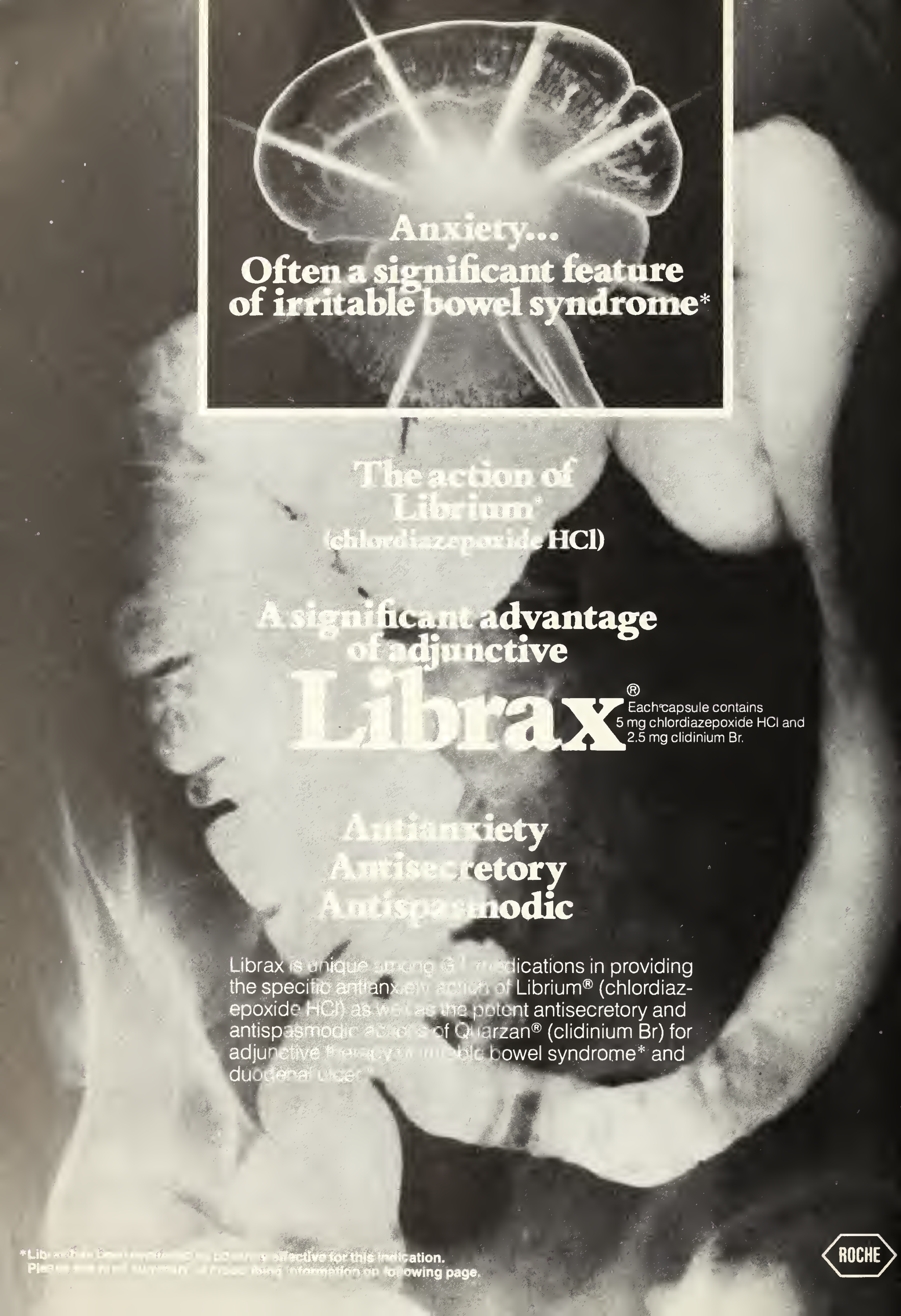
One area that repeatedly presents legal problems is psychiatric care. The law does not define psychiatric illness as an emergency, so parental consent is required. But a life-threatening situation — such as a suicide attempt — would allow you to act under the emergency exemption.

Coming Up Soon for MSMS Members

MSMS Annual Scientific Meeting, Nov. 7-8-9

Coming soon in Michigan Medicine will be some of the details for the 1978 MSMS Annual Scientific Meeting. Physicians will again be able to combine a mini-vacation with the spouse with the chance to earn Category I CME credits.

(See page 375 for more details.)



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Librax is unique among GI medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy in irritable bowel syndrome* and duodenal ulcer.*

*Librax has been evaluated as possibly effective for this indication.
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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701

MDs important link to Child Find

I am writing to describe for physicians Michigan's Project Child Find. The medical profession can be such an important part of Project Child Find, a state-wide effort to find people from birth through age 25 who have special educational needs. We plan to see the appropriate services are found for each person. We are especially concerned with finding preschool children who have special educational needs. They may have problems in the following areas: vision, hearing, speech and language, learning disabilities, mental impairments, emotional development, and physical or health problems.

Physicians, through their contact with children and families, can assist in this project by observing possible developmental problems and urging the family to contact the Special Education Office in their school district. To obtain more information about Project Child Find, please write or call a local special education office or Janell Dennis, State Coordinator for Project Child Find, at 313/767-5750, Mott's Children Health Center, 806 W. 6th Avenue, Flint.

Hotline helps

Michigan physicians now can refer families of children with special educational needs to a "hotline" phone number for assistance.

The Michigan Board of Education announces that the toll-free, 24-hour phone number is 800-572-6955. John W. Porter, state school superintendent, reports the program will help children with problems with hearing, vision or speech — or mental, physical or emotional impairment.

Michigan was the first state to pass legislation in 1971 requiring that each handicapped citizen to age 25 be provided with special education services.

Business

Real estate tax shelter has attractive advantages for MDs

By Gary W. Brya, CPA
Lansing

Are there any methods left that can reduce the physician's tax bill? Fortunately, even with today's high taxes, the answer is still, "Yes."

As a result of the Tax Reform Act (TRA) of 1976, significant changes were made in the tax shelter area. However, the one shelter which seemed to escape the congressional scalpel for the most part was the real estate tax shelter. This article will explore the nature of a real estate tax shelter, how it operates, and its tax effect to a physician who may invest in such a shelter.

What is a real estate tax shelter?

There are three basic tax aspects of the real estate tax shelter. First, it should shelter some of the investor's income from the highest or marginal tax rate by being declared a loss and thereby reducing other income currently being earned by the physician. These losses are generally artificial in nature, and are generated through accelerating the tax deductions attributable to the shelter. The second aspect of real estate is that it can be leveraged to finance the cost of the property. This then minimizes the down payment required by the investor and increases his return on investment. The third aspect is that the real estate tax shelter allows for partial capital gains treatment upon the ultimate disposition of the shelter rather than all ordinary income. The 1976 changes in the law increased the depreciation that is recaptured as ordinary income, but still left an opportunity of obtaining substantial capital gains.

How a real estate tax shelter operates

The most common entity used in establishing a real estate investment is a partnership. This can be either a general partnership or, more often, a limited partnership. The latter provides the investor with limited liability with respect to his cash investment plus any additional contributions as called for in the agreement. A corporation usually acts as the general partner while the investors are the limited partners. With the partnership form, tax losses and other tax attributes are passed through to the partners. In order to explain the operation and the tax consequences of a real estate shelter an example may be helpful. In a limited partnership with a group of 10 physicians as limited partners, we will assume that each partner contributes $50,000. The partnership then buys or has constructed a new residential apartment complex for $4,000,000. A down payment of $400,000 is made and a non-recourse mortgage on the property is obtained for $3,600,000 payable over 30 years.

Because we are dealing with new residential property, accelerated depreciation at the rate of twice the straight line rate can be used. (This is often referred to as double declining rate of depreciation.) We will assume that the purchase price is allocated as follows: $500,000 to the land and $3,500,000 to the building. With a 40-year life on the building, we would have a depreciation deduction in the first year of $175,000 (3,500,000 ÷ 40 years = $87,500 × 2 = $175,000). Generally, the amount allocated to the building is further broken down between real property and personal property. This allows a much shorter life to be used on the personal property. In addition, the real property can be divided into its various component parts with appropriate lives assigned to each component. This allows such costs as the heating, plumbing, roofing, electrical and others to be depreciated over a much shorter life than 40 years.

In projecting the income statement of the partnership, it might appear as follows:

Income		$600,000
Expenses-operating		240,000
Profit before depr. & int.		360,000
Interest	$315,000	
Depreciation	175,000	490,000
Tax Loss		$130,000

Each physician is entitled to his share of the loss or $13,000 as an offset against the income from his practice. Since a non-recourse loan exists, this partnership liability of $3,500,000 is allocated to each partner and is added to their cash investment to compute their total basis in the partnership. Losses can then be taken by each partner up to his basis of $400,000 ($50,000 + $350,000). This allows each partner to take a deduction far in excess of his actual cash outlay in the partnership. The TRA of 1976 set no restric-

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Mr. Brya is a principal in the firm of Maner, Costerisan & Ellis, PC, Lansing. He has been a certified public accountant for seven years and is currently in charge of the firm's tax department.

tions on this procedure so long as the principal activity of the partnership is investing in real estate.

In a true tax shelter, this loss is generally only a paper loss which is created by the accelerated depreciation allowed on the real estate. In reality, there should actually be a cash profit or positive cash flow from the operation of the property. This might be illustrated as follows:

Income	$600,000	
Expenses - operating	240,000	—
Profit before debt service		$360,000
Interest	315,000	
Principal	20,000	335,000
Cash flow		$ 25,000

This cash flow is then generally available to be distributed back to the partners tax-free. In most cases, due to start-up costs and the need for full occupancy, the cash flow back to each partner may not begin until the third or fourth year after operation.

In addition to the shelter and the leveraging of the property, the last important factor in a real estate tax shelter is the appreciation in the property. This appreciation in the real estate provides some hedge against inflation as well as providing some capital gain to the physician rather than ordinary income. Although the Tax Reform Act of 1976 now generally requires all excess depreciation (total depreciation minus straight line depreciation) on real property to be recaptured as ordinary income, any gain over and above the excess depreciation is treated as capital gain.

In considering the three factors of the tax shelter, we can now compute the return on investment that can be generated from a real estate shelter. In our example, the physician at a 50% tax rate can save $6,500 in income tax and also receive $2,500 in actual cash. When you compare this total return to his investment of $50,000, he is receiving an approximate return on investment of 18% virtually tax-free. This is without considering any appreciation on the property that will ultimately be recognized when the property or his interest in the partnership is sold.

Possible pitfalls

All of this may seem relatively easy, but there are some problems and pitfalls that can occur with a real estate tax shelter. They are mentioned here only briefly to alert the potential investor before entering into a shelter. They can be summarized as follows:

1. Accelerated depreciation on real property is a tax preference item which when added to other tax preference items may result in some minimum tax.

2. If a partner sells his interest in the partnership or the apartment complex is sold, the partner may have a substantial gain even though he may receive little or no cash. This problem is not well known, and is an often overlooked tax trap of real estate tax shelters. This is caused by the fact that the investor includes his share of partnership liabilities as part of his total basis in the partnership. When property or his interest is sold, the gain recognized is the difference between the amount realized and the partner's adjusted basis in the partnership. In determining the amount realized, the partner must include his share of liabilities from which he is relieved. Because of this problem some units are sold on a contract basis and the installment sale provisions are elected. In some cases there is no easy way out, particularly in a cash sale.

3. The depreciation recapture provision will result in part of the gain being taxed as ordinary income upon disposition. After 1975, excess depreciation is completely recaptured but not in excess of the gain on the property.

4. The Tax Reform Act of 1976 made several changes which affect the real estate tax shelter and decrease the amount of losses which can be claimed in the earlier years. These changes include a limitation on pre-paid interest, the amortization of organizational expenses, the capitalization of syndication fees, the regulation of special allocations of the various tax attributes between partners and the limitation of retroactive allocations of losses prior to the actual investment by a partner in a partnership.

5. At some point in time, usually about eight or 10 years after the purchase, the tax shelter will no longer be a shelter, but will generate income taxable at the physician's marginal tax rate. This is due to the reduction in the accelerated depreciation from the property. At this point, the investor may want to sell his interest and acquire a larger shelter or simply buy another shelter.

Conclusion

The real estate tax shelter may not be the answer for everyone, but even after the Tax Reform Act of 1976, it has many attractive features. In deciding whether to invest in a real estate tax shelter or any other shelter for that matter, the investor should consider the following items:

1. The potential risk of the investment.

2. The tax loss generated from the investment.

3. The cash flow, if any, to be received by the investor.

4. The appreciation, if any, in the underlying assets of the shelter.

5. The total return on investment from the shelter.

6. The ease of transferability of the investment.

7. The amount of management time and skill required by the investor.

8. The economic reality of the transaction and the investment.

If the above items are considered when making an investment, the tax shelter should provide a substantial tax savings while at the same time increasing the physician's overall net worth. A real estate shelter will generally receive a favorable answer to all of the above items except for the ease of transferability with respect to a limited partnership interest. A real estate tax shelter may be something worth considering in the future.

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CEFAZOLIN SODIUM
(LYOPHILIZED)

For serious respiratory infections
due to susceptible indicated organisms

Bactericidal *in vitro* against susceptible strains*

IV/IM Dosage Flexibility

'Ancef' may be given either IM or IV at the same dosage schedule.

Most infections can be treated with 500 mg. to 1 gram every 8 hours.

(See complete prescribing information in *PDR* or SK&F literature for full dosage instructions.)

Well Tolerated

Infrequent phlebitis; no nephrotoxicity reported. Transient rises in BUN, SGOT, SGPT and alkaline phosphatase have been reported without clinical evidence of renal or hepatic impairment.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

***Respiratory tract infections** due to *Streptococcus (Diplococcus) pneumoniae*, *Klebsiella* species, *Hemophilus influenzae*, *Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli*, *Proteus mirabilis*, *Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus*.

Septicemia due to *Str. pneumoniae*, *S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis*, *E. coli*, and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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It's up to MD to have efficient practice

By Gerald E. Butler, MD, FACS
Ann Arbor

We physicians are the principal reasons our offices are either efficient or inefficient. Why do I say this?

I have been in practice 18 years. As I look back on those years, and at my colleagues' and my own experiences, I can draw some conclusions and make some suggestions to help us be more efficient and aid our patients in their health care.

I think too many physicians are reluctant to spend money to make money. We work in offices which are totally outdated. With modest investments in our offices, time spent in actual practice relative to gross income can be dramatically changed for the better.

I think we must insist upon accurate and realistic scheduling. This is our job. If our dentist, lawyer, or accountant was habitually late with our appointments, would we continue to see them? Of course not. No patient should wait more than 15 or 20 minutes for our services. If they do, it is our fault and we should correct our scheduling practices.

Office staff

We must establish criteria for a loyal, hard-working office staff. This can be accomplished by an office manual describing job duties, fringe benefits, vacation and sick time.

All employees should be able to do all office jobs. It's too common that just one of our employees will do the books. This can lend itself to embezzlement and creates chaos when this employee goes on vacation or is ill.

Our best employee should act as office manager. This position alleviates the petty details we otherwise would be burdened with in operating an office instead of practicing medicine.

We must have enough office space. If we don't, we should move or renovate. If our office patterns are such that we waste time, then remodeling or moving is the most economical thing to do, however painful at the time.

Our personnel must protect us from the phone. The typical patient that must talk to us usually ends by requesting an appointment. We should be sure, however, that office help have very definite guidelines. If we don't, we will create some very unhappy patients and referring doctors.

A good filing system is extremely important. If our employees can't find a record promptly, it costs money. We can consider microfilming old records. Filing cabinets cost money and take up space, costing so much per square foot per year.

Our offices should be easy to get to.

Handling of statements and insurance forms can be simplified by using a pegboard system of some kind. This is not only efficient but again makes embezzlement extremely difficult. If we check the books every day, even a cursory look will let employees know we are monitoring what they do.

Office equipment

We needn't spare costs of office machinery. An automatic typewriter and copying machine may save the salary of an extra person who would be doing the same job by hand.

It's amazing to me how few doctors seem to have an office employee who can type well. Under these circumstances, we can't send letters to colleagues about their patients. Another helpful item is a postage meter. What bigger waste of time for our help than licking stamps and sealing envelopes?

In my office I have centralized dictation equipment. My desk isn't cluttered and I can put down my thoughts as they occur. Along with this goes a phone line that dials direct to office equipment. This allows me to notate patients' charts when not at the office, on weekends or nights.

A good intercom system is another must. This does not include a phone in the examination rooms — I've tried it and found it inappropriate to discuss one patient in the presence of another.

It's wise to spend money on paper goods. We all use a limited amount of medications, and can have our basic armamentarium preprinted, needing only the patient's name and our signatures. I have developed booklets for basic procedures. They make for good informed consent and give the patient something to refer to when we're not there. They also save our offices, and us, a lot of phone time and interruptions.

In closing I can only say that time is the most precious thing we have. We must use it wisely!!

Doctor Butler is a practicing otorhinolaryngologist in Ann Arbor, Michigan.

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Certified business consultant your best bet for help

By John A. Richards, Chief
MSMS Bureau of Economics

If you've decided your practice requires the assistance of a business consultant, your next decision is your selection of the individual to do the consulting.

It will be to your advantage to comparison shop. One factor you may want to consider in your selection is whether the prospective consultant is a member of the Institute of Certified Professional Business Consultants and has earned the right to use the designation, "Certified Professional Business Consultant (CPBC)."

Five years' experience

A CPBC must have devoted at least five years exclusively to the field of management consulting for professionals. This insures the person you are considering has experience and is aware as a professional you have a business with unique features and problems.

The second criterion necessary for a CPBC is successful completion of a competitive examination encompassing all major elements of practice and financial management. This examination was developed with the assistance of Harcourt, Brace, Jovanovich, Inc., a nationally recognized authority on test development, and was first officially administered in 1971.

Certification is by examination only, there being no grandfathering or modified certification. The level established to pass the test is high enough to make the test genuinely competitive and demanding, and the test requires demonstrated proficiency in both practice and financial management, as independent subjects.

Code of ethics

In addition, a CPBC has agreed to conform to the Institute's Code of Ethics and Rules of Professional Conduct. The Code of Ethics includes provisions requiring the consultant to act in the best interests of clients at all times, to derive professional compensation directly from clients, and to refrain from activities which may constitute a conflict of interest. The code also requires the consultant to consider all information from clients confidential and to make full disclosure of activities upon request of a board of examiners if there is a question regarding activities while serving clients.

The choice of a business consultant is highly personal and requires careful consideration by the physician. By selecting an individual who has earned the right to use the designation CPBC you can be confident that person is experienced and fully committed to the specialty.

Adult blacks to be surveyed by U-M researchers

University of Michigan researchers soon will conduct the first truly representative household survey of adult black Americans. It will be funded by the National Institute of Mental Health.

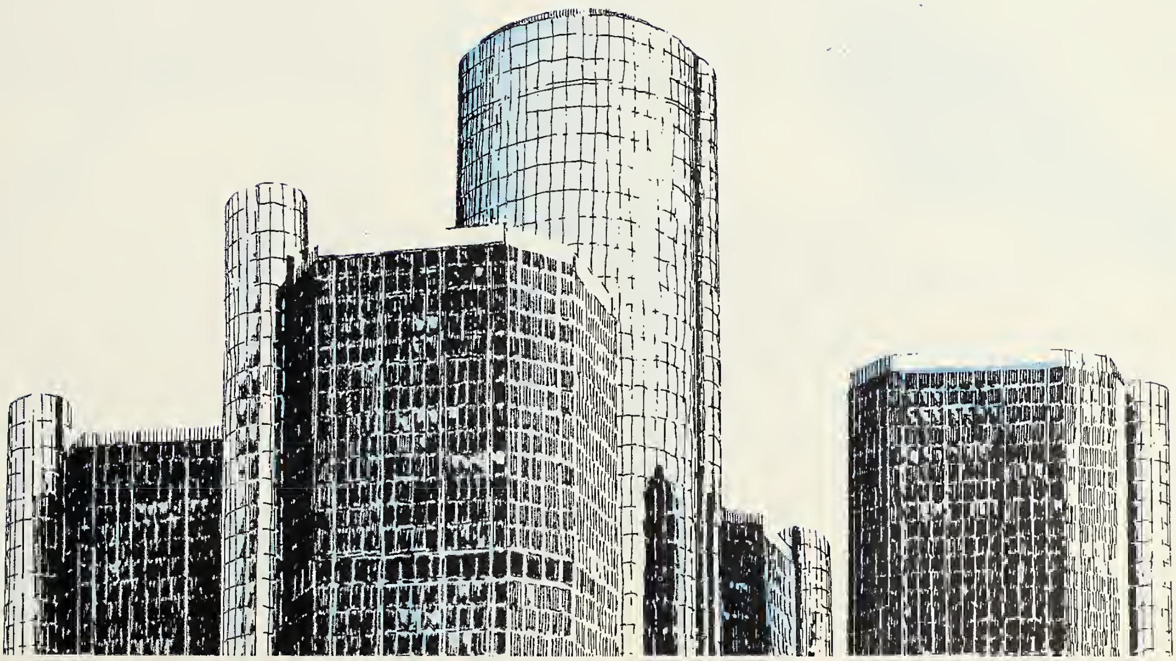
Representatives of the U-M Institute for Social Research (ISR) will conduct more than 2,000 personal interviews in the spring of 1979 with a representative sampling of black people in the 48 continental states. Preliminary interviewing has begun.

Survey results are expected to provide social researchers, policy makers, and the black community with the first opportunity to make stable estimates of the entire black population in a number of important health-related areas.

Mark Your Calendars Now

Detroit, Nov. 7-8-9,
MICHIGAN STATE
MEDICAL SOCIETY

Recognize the building? Popping out of the Detroit horizon is the spectacular building that will be utilized by MSMS for the big 1978 MSMS Annual Scientific Meeting.



Category I courses

***Michigan Medicine** each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: **July 21-22, Mental Health Audit Seminar. Location:** Hilton Inn, 7501 W. Saginaw Highway, Lansing. **Sponsor:** Interqual, Chicago. **For:** All mental health professionals. **Cost:** $150. **Contact:** Monica Eckart, Seminar Registrar, 312/751-2327, or 800/621-6109. **Approved for:** 12 hours of Category I Credit.

Date: **July 24-25, Oculo-Plastic Surgery. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists/Surgeons. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12 hours of Category I Credit.

Date: **July 27-28, 1978 Coller-Penberthy-Thirlby Conference. Location:** Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center, Traverse City. **For:** All specialties. **Cost:** $25. **Contact:** Thomas Auer, MD, % Munson Medical Center, Traverse City, 49684. **Approved for:** 9 hours of Category I Credit.

Date: **July 29-August 2, 32nd Annual Convention and Scientific Assembly, Michigan Academy of Family Physicians. Location:** Sugar Loaf Village, Cedar. **Sponsor:** MAFP. **Cost:** $65 members, $75 non-members. **Contact:** Rita Feldkamp, (313) 455-4200. **Approved for:** 30 hours of Category I Credit.

Date: **July 31-August 4, and November 6-10, Principles of Milieu Practice: Working with the Elderly in Treatment Settings. Location:** University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 35 hours of Category I Credit.

Date: **Aug. 21-Aug. 26, Fifth Regional Congress of the International College of Surgeons. Location:** North Detroit General Hospital, Detroit. **Sponsor:** North Detroit General Hospital. **For:** Surgeons. **Contact:** M. O. Cantor, MD, 4850 Charing Cross Road, Bloomfield Hills, 48013, 313/646-3320. **Approved for:** 45 hours of Category I Credit.

Date: **Aug. 25-28, Infectious Diseases. Location:** Mackinac Island. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family Physicians, Internists. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: **Sept. 11-13, The Neck, Shoulder and Upper Extremities in Sports. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** American Academy of Orthopaedic Surgeons. **Cost:** $150, AAOS members; $200, non-members. **Contact:** American Academy of Orthopaedic Surgeons, 430 N. Michigan Avenue, Chicago, 60611. **Approved for:** 18 hours of Category I Credit.

(Continued on page 378)

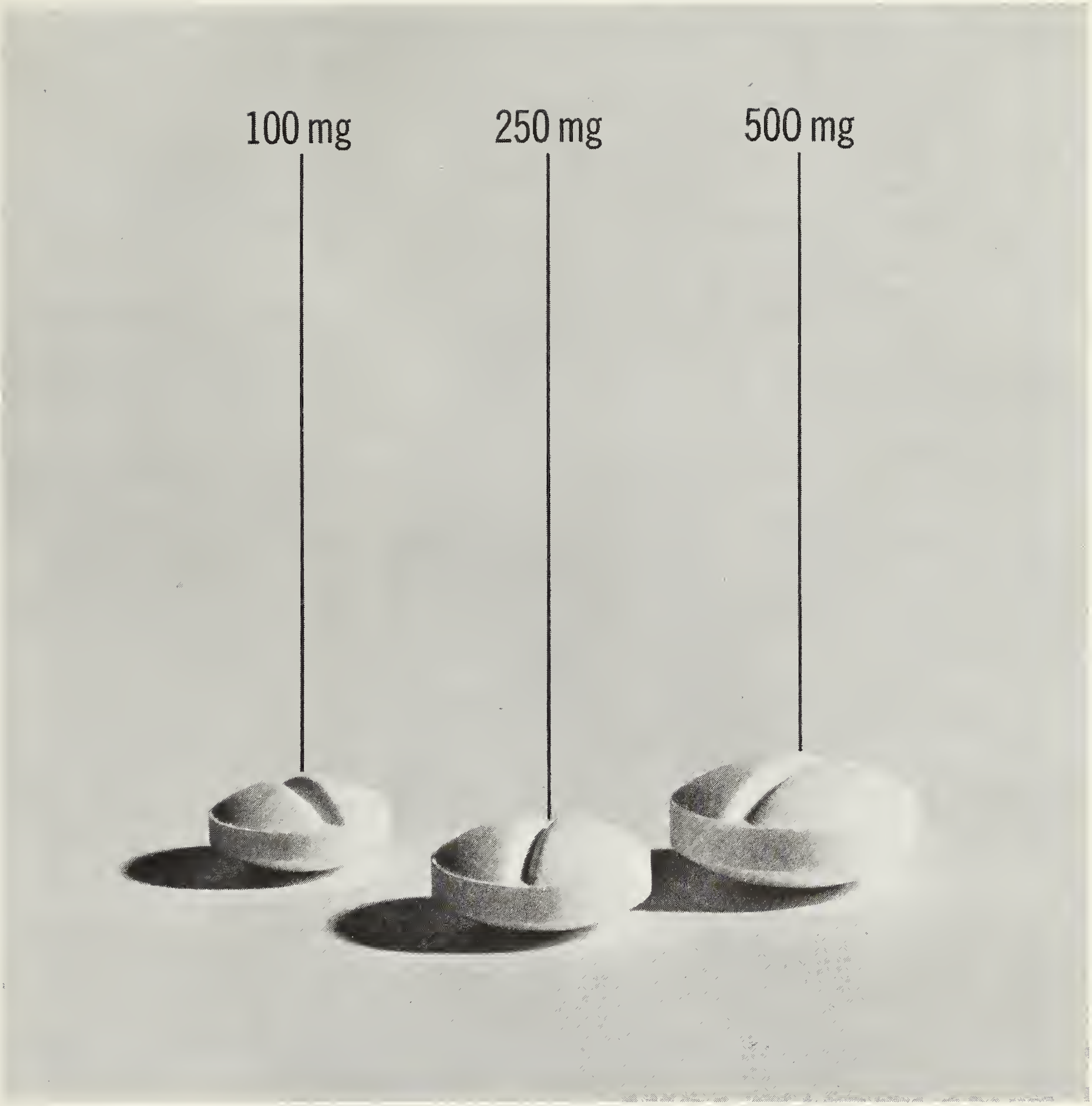
The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

- American Association for Hand Surgery, Warren
- American College of Emergency Physicians, Lansing
- American College of Psychiatrists, Southfield
- American Society of Colon and Rectal Surgeons, Detroit
- Ann Arbor Psychiatric Association
- Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
- Commission Professional and Hospital Activities, Ann Arbor
- Michigan Academy of Family Physicians
- Michigan Academy of Plastic Surgery
- Michigan State Medical Society
- Michigan State University College of Human Medicine, East Lansing
- Michigan Chapter, American Academy of Pediatrics
- Michigan Dermatological Society
- Michigan Heart Association
- Michigan Lung Association, Lansing
- Michigan Society of Anesthesiologists
- Noah Worcester Dermatological Society, Detroit
- Section of Gastroenterology, American Society for Gastroenterology, Detroit
- University of Michigan Medical Center, Ann Arbor
- University of Michigan School of Public Health
- Wayne State University School of Medicine, Detroit

Hospitals:

- Alma-Gratiot Community Hospitals, Alma
- William Beaumont Hospital, Royal Oak
- Beyer Memorial Hospital, Ypsilanti
- Blodgett Memorial Hospital, Grand Rapids
- Bon Secours Hospital, Grosse Pointe
- Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
- Butterworth Hospital, Grand Rapids
- Central Michigan Community Hospital, Mt. Pleasant
- Chippewa County War Memorial Hospital, Sault Ste. Marie
- Community Health Center of Branch County, Coldwater
- Community Hospital Association of Battle Creek
- Cottage Hospital of Grosse Pointe
- Detroit-Macomb Hospital Association
- Ferguson-Droste-Ferguson Hospital, Grand Rapids
- Grace Hospital, Detroit
- Hawthorn Center, Northville
- Henry Ford Hospital, Detroit
- Holy Cross Hospital, Detroit
- Hurley Medical Center, Flint
- Ingham Medical Center, Lansing
- Kalamazoo Regional Psychiatric Hospital
- Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
- Leila Y. Post Montgomery Hospital, Battle Creek
- Marquette General Hospital
- McLaren General Hospital, Flint
- Mercy Hospital, Port Huron
- Metropolitan Regional Psychiatric Hospital
- Midland Hospital Center
- Mt. Carmel Mercy Hospital & Med. Center, Detroit
- Munson Medical Center, Traverse City
- North Detroit General Hospital, Detroit
- Oakland Medical Center, Pontiac
- Oakwood Hospital, Dearborn
- Pennock Hospital, Hastings
- Pontiac General Hospital, Pontiac
- Port Huron Hospital CME Committee
- Providence Hospital, Saginaw
- Saginaw Cooperative Hospitals, Inc., Saginaw
- Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
- St. Francis Hospital, Escanaba
- St. John Hospital, Detroit
- St. Joseph Hospital, Flint
- St. Joseph Mercy Hospital, Pontiac
- St. Joseph Mercy Hospital, Ann Arbor
- St. Lawrence Hospital, Lansing
- St. Mary's Hospital, Grand Rapids
- St. Mary Hospital, Livonia
- Sinai Hospital of Detroit, Detroit
- Southwest Detroit Hospital
- Edward Sparrow Hospital, Lansing
- Traverse City State Hospital Traverse City
- V.A. Hospital, Battle Creek
- West Shore Hospital, Manistee
- Ypsilanti State Hospital, Ypsilanti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CATEGORY I/*continued*

Date: **Sept. 13, Third Annual Renal Disease Conference. Location:** Kalamazoo Center, 100 West Michigan, Kalamazoo, 49006. **Sponsor:** Michigan Nephrology Center. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians, Internists, General Practice, Nephrologists. **Cost:** $35. **Contact:** Jeffrey Block, M.D., Michigan Nephrology Center, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 19-22, Blood Coagulation. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Medical Technologists, pathologists. **Cost:** $225/$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: Sept. 21, 22, 23. Implant Surgery for Joints and Tendons in the Hand. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Cost:** $200. **Contact:** Alfred B. Swanson, MD, Chairman, 290 Blodgett Professional Bldg., Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 23-24, Current Concepts of Respiratory Care. Location: Sugar Loaf Mountain. **Sponsor:** Michigan Society of Anesthesiologists and Wayne State University School of Medicine. **For:** Practicing anesthesiologists. **Cost:** $100. **Contact:** Wayne State University School of Medicine, Div. of CME, 540 E. Canfield, Detroit, 48201, 313/577-1180. **Approved for:** 9 hours of Category I Credit.

Date: Sept. 28, J. L. Wilson Symposium. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians. **Cost:** $30. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 5 hours of Category I Credit.

Date: Sept. 28-29, Coping with Changes in the Later Years. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 30, Michigan Society of Pathologists September Seminar, "Cardiovascular Diseases." Location: Sinai Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: Oct. 3, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 6, 7, 8, Annual Meeting, Michigan Chapter of the American College of Physicians. Location: Otsego Ski Club, Gaylord. **Sponsor:** Michigan Chapter, American College of Physicians. **Contact:** Boy Frame, MD, FACP, ACP Governor for Michigan, 543 Lakepointe, Grosse Pte. Park, 48230. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 16-20, Family Practice Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: Oct. 18, Diabetes for the Clinician. Location: Kalamazoo Center, Kalamazoo. **Sponsor:** American Diabetes Association, and The Upjohn Company. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Family physicians and internists. **Cost:** $25 physicians, $10 house officers. **Contact:** C. L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 252 East Lovell Room 364, Kalamazoo, 49006, (616) 383-6360. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 25, Brief Psychotherapy. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, psychotherapists. **Cost:** $50/$30. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 27-28, Otorhinolaryngology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otolaryngologists. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12 hours of Category I Credit.

Date: Nov. 2, Second Annual Michigan Family Practice Research Day. Location: MSU University Club, East Lansing. **Sponsor:** Department of Family Practice, MSU College of Human Medicine, and Michigan Academy of Family Physicians. **Contact:** Doug McKeag, MD, Chairman, Research Day Planning Committee, MSU Department of Family Practice, East Lansing, 48824, 517/353-0850. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 6-8, Minimal Breast Cancer. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists, surgeons, hematologists. **Cost:** $160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: November 6-10, Counseling Older Adults and their Families; Principles of Milieu Therapy: Working with the Elderly in Treatment Settings. Location: University of Michigan. **Sponsor:** Institute of Gerontology, University of Michigan. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 3.5 hours of Category I Credit.

Date: Nov. 7-9, MSMS Annual Scientific Meeting. Location: Detroit Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** MSMS. **For:** All specialties. **Cost:** To be determined. **Contact:** Herbert Auer, MSMS headquarters, 517/337-1351. **Approved for:** 20 hours of Category I Credit.

Date: Nov. 13-14, Oncology-Hematology. Location: Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Primary care physicians. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Nov. 17-18, Medical-Surgical Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians, surgeons. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Dec. 5, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Jan. 18-20, Rheumatology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Rheumatologists, internists, family physicians. **Cost:** $150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: Feb. 4-9, Family Practice Update. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $200. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: Feb. 15, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 19-23, Emergency Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians, internists, emergency physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 35 hours of Category I Credit.

Date: Feb. 27-28, Psychophysiologic Illness. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, primary care physicians. **Cost:** $100. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't of PGM/HPE, Ann Arbor, 48109, (313) 764-2287.

**WSU Division of CME, Room 1206, Scott Hall, 540 E. Canfield, Detroit, 48201 (313)577-1180.

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

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Courses planned already for 1978 MSMS Annual Scientific Meeting

There will be 55-60 half-day Category I Credit courses offered Nov. 7-8-9 by MSMS at the spacious Detroit Plaza Hotel to help physicians learn what's new and practical in a very wide range of medical matters.

The advance planning for the 1978 Annual Scientific Meeting is far ahead of the 1977 schedule. The first planning session for the upcoming program was held Oct. 3, 1977, more than a year before the event is scheduled. Committee contacts with the specialty societies and medical schools zoomed ahead in February of 1978.

A planning meeting at the Detroit Plaza on June 8 heard about course plans, invitations accepted by prominent speakers and proposed special events.

"The MSMS Council is proud and pleased with the work done already for the 1978 Scientific Meeting," declared Louis R. Zako, MD, Council chairman, at the June 8 meeting. He praised the work of the MSMS Committee on CME Programming, chaired by Carl Hammerstrom, MD, Marquette, and the effective planning by Robert F. Wilson, MD, Detroit, who is serving as program chairman again.

The specialty societies and the departments of the three medical schools were thanked by Doctor Zako for organizing practical, half-day courses that meet the tough Category I credit criteria.

The general format for the 1978 Scientific Meeting will follow the new pattern started in 1976 when 46 half-day Category I courses were offered. The number increased in 1977 to 56 courses. Both those events were held at the Dearborn Hyatt Regency which is being enlarged now. MSMS will move the 1978 fall program to the Renaissance Center and the Detroit Plaza.

Doctors Hammerstrom and Wilson have appointed course directors and authorized them to obtain the best possible instructors from the three Michigan medical schools, from the ranks of practicing Michigan physicians, and from medical schools across the nation.

Beginning with the August issue, *Michigan Medicine* will spotlight some of the noted medical educators coming from other states to confer with Michigan physicians this coming November.

"We encourage MSMS members to block out their appointment calendars now for Nov. 7-8-9 and plan to participate," stressed Doctor Hammerstrom. Doctor Hammerstrom thanked Doctor Wilson for his efforts to plan courses that will meet the needs and interests of practicing Michigan doctors. Available for study were (1) evaluation reports from each of the 1976 and 1977 courses, (2) a summary of the questionnaire which asked 1977 participants what courses they would like to have offered in 1978, (3) survey returns from specialty societies and medical school departments indicating which 1976 and 1977 courses should be repeated, and (4) information about the various courses offered by the AMA to meet the needs of physicians expressed at the various regional programs.

The MSMS Committee for CME Programming, chaired by Doctor Hammerstrom, heard progress reports at the January, March, April and May meetings of the Committee. The Committee has been accredited to grant Category I credit toward the AMA Physicians' Recognition Award and the state licensing requirements.

Look for complete course list in Medigram

MSMS members soon will receive a *Medigram* that will list all the courses being planned for the 1978 MSMS Annual Scientific Meeting at the Detroit Plaza Nov. 7-8-9.

The preliminary program is being mailed now so that doctors can plan their CME activities this summer.

"We want doctors to decide now to come to the big fall meeting to earn Category I credits and learn about medical subjects that interest them," explains Carl F. Hammerstrom, MD, chairman, MSMS Committee for CME Programming.

The two leaders for the 1978 MSMS Annual Scientific Meeting pause during their recent inspection of the Detroit Plaza — where the physicians will gather Nov. 7-8-9. Carl F. Hammerstrom, MD, left, chairman of the MSMS Committee for CME Programming, and Robert F. Wilson, MD, program chairman for the meeting, conducted a planning session June 8 for the course directors at the spacious, new hotel in Detroit's Renaissance Center.

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Calendar for AMA, MSMS, auxiliary and medical assistants

(See also listing of Category I programs on page 376)

July 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

July 22-23 — Summer Seminar of the American Association of Medical Assistants, State of Michigan, Schuss Mountain, Mancelona, contact: Helen Schulte, MSMS headquarters.

Sept. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

Nov. 1 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 7-9 — MSMS Annual Scientific Meeting, Detroit Plaza Hotel, contact: Herb Auer, MSMS headquarters.

Dec. 2-6 — AMA House of Delegates Interim Meeting, Chicago.

Dec. 7 — AMA Winter Scientific Meeting, Las Vegas.

Dec. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Ohio med ed group seeks memberships

Applications are now being invited for membership in the Ohio Medical Education Network (O-M-E-N), which begins its 17th year of service in mid-September. OMEN is the largest, accredited, two-way, visually augmented, amplified telephone network for physicians in North America.

During this past season, medical staffs at 109 hospitals in seven states and Canada took part in the CME seminars. While the programs *originate* "live" from the Ohio State University campus in Columbus, the conferences are actually *held* at participating hospitals, many of which are located hundreds of miles away.

Each of the 30 once-a-week programs begins at 12:30 p.m. Eastern time, and lasts one hour. One hour of category 1 credit is available for each program from the American Medical Association. Continuing education study credit is also provided by the American Association of Family Physicians, and the American Osteopathic Association. The 1978-1979 season starts the week of Sept. 19, 1978 and continues through the first week of May, 1979 with "time off" during Thanksgiving week, Christmas week, and New Year's week.

Individuals wishing more complete information on the network are invited to call: (614) 422-4986, or write:

Arthur A. Bartfay,
Networks and Media Coordinator
Center for Continuing Medical Education
The Ohio State University
A-354 Starling Loving Hall
Columbus, Ohio 43210

JAMES MARQUETTE

Plan a Mini-Vacation, Earn Category I Credit

MSMS will offer a weekend of Category I CME courses Saturday and Sunday, September 23-24 at Northern Michigan University campus.

Rooms are available at Marquette Holiday Inn

For details, write to:

MSMS CME Committee
120 West Saginaw
East Lansing 48823

Visit Marquette and the upper peninsula this fall

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
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For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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IN THE DETROIT AREA, STAPH RESISTANCE HAS NOW REACHED 85%.*

resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

TEGOPEN®

(cloxacillin sodium)

..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.

- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.

Please see brief summary
for prescribing information.

MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, a sample question, with answer, is printed here. Future issues will carry more.

Mr. Drost

FOR: Laurence Drost, director, Medicaid Information Division, Michigan Department of Social Services

"How do I get information about the Medicaid Program?"

The primary function of the Medicaid Information Division (MID) is to provide Medical Assistance Program information to Medicaid providers and recipients. In addition, MID is the liaison between the Medical Services Administration and the news media, the general public and Federal and State governments.

MID is divided into distinct sections; one is for information, the other for services.

The MID information section has the following units:

HOT LINE (1-800-292-2550): Your telephone calls to the toll-free number are taken in this unit. The telephone representatives answer questions about policy, coverages, and billing procedures. If a problem cannot be resolved immediately, the questions will be researched and an answer obtained. *Complex problems may require written inquiries.* If you feel fraud may be occurring, please notify this unit; they will refer the suspicion for investigation.

PROVIDER ENROLLMENT: Requests for Medicaid participation, address changes, and any other changes affecting provider identification should be mailed to this unit.

CORRESPONDENCE UNIT: Written questions about policy, coverages, and billing procedures are answered by this unit.

CLAIMS RESEARCH AND ANALYSIS: Questions requiring research (written and telephoned) will be resolved in this unit and an answer returned to the provider.

FORMS DISTRIBUTION: Written requests for manuals, bulletins, flyers, and billing forms are processed through this unit.

The services section has the following units:

PROVIDER PUBLICATIONS: All changes in policy or procedures are written in the form of bulletins, flyers, or letters for distribution to providers. As new programs are offered by Medicaid, new manuals are created.

FIELD REPRESENTATIVES: When billing problems become very complex or severe, providers should request the services of a field representative. The representative will visit the provider, review the documents and offer a solution. (Requests for visits can be made in writing, at seminars, or by calling the Hot-line).

SEMINARS: These presentations review recipient eligibility, coverages and limitations, billing procedures, as well as discussing general questions and problems. Providers having billing problems are encouraged to bring supporting documents, and possibly the problems can be resolved. Seminar booklets are mailed semi-annually to notify providers of seminar dates and reservation procedures.

If you have a question and are unsure where to send it, or if your question has been answered by MID personnel but you feel that it is still not resolved, contact Laurence A. Drost, Director, Medicaid Information Division. Medical Services Administration, 300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909.

Editor's Note: One of the functions of the MSMS Medicaid Liaison Committee is to intervene on behalf of physicians who cannot achieve resolution of Medicaid payment and procedural problems. However, with the encouragement of MSMS over the past several years, the Department of Social Services has expanded the resources and services of the Medicaid Information Division so that many initial problems can be resolved without the intervention of the Medicaid Liaison Committee. If the services described in this description of the Medicaid Information Division do not resolve Medicaid problems, physicians should write to the MSMS Medicaid Liaison Committee for assistance.

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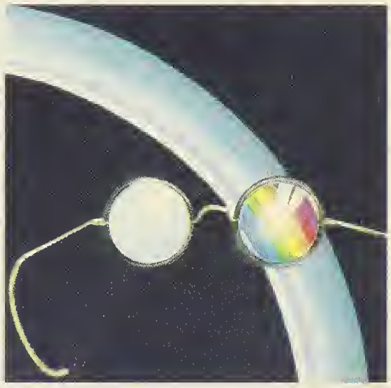
"In a real dark night of the soul it is always three o'clock in the morning."

—F. SCOTT FITZGERALD
THE CRACKUP, 1936

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime![1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

[1] Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.



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in shades of blue...
help them see life
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Brief Summary of Prescribing Information
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Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.

The AMA Computer Systems in Medicine Consultative Services Program

The American Medical Association recognizes the potential that computers have in the health care setting. Therefore, the AMA has initiated the **Computer Systems in Medicine Consultative Services Program.** Through this program, physicians who are considering computer services as well as current users who want to improve or expand their computer applications can obtain an objective viewpoint and expertise in methods and equipment.

Computers have the potential to be a tremendous asset to the medical community, and have possible application in some or all of the following:

- Improving patient care
- Creating more accessible medical records
- Improving financial management and control
- Reducing the rate of increasing costs
- Improving facility and personnel utilization

The **Consultative Services Program** has established expertise extending from general decision-making on the utilization of computers in medicine to detailed systems design, programming and implementation of systems. The Program's activities include: needs analysis; alternatives development; specifications development; proposal evaluation; and systems audits.

While the major thrust of the **Consultative Services Program** will result from interest in the use of computers or computer-related services, the primary goal of the consultant is to recommend the most advantageous treatment of each situation. **The focus is the needs and objectives of the client,** not the promotion of computerized solutions.

For a more detailed description of this new and valuable service or to arrange a consultative visit, contact: John A. Guerrieri, Jr., Program Director, Consultative Services Program, at (312) 751-6417.

'Physicians very precise, and they evaluate your credibility,' journalism students told

(The following news release by MSU Information Services reporter Fred Bruflodt resulted from the MSMS seminar.)

Dig into the reason why somebody is criticizing some official program, reporter Steve Jensen told student journalists at Michigan State University.

"Look for their hidden agenda, as well as the hidden agenda of the officials," warned Jensen, news director for WKAR-AM and FM, MSU's public radio stations.

Jensen, along with other reporters, physicians and public relations people in the health care fields participated in a half-day workshop on "Problems in Medical Reporting" presented by the MSU School of Journalism and the Michigan State Medical Society.

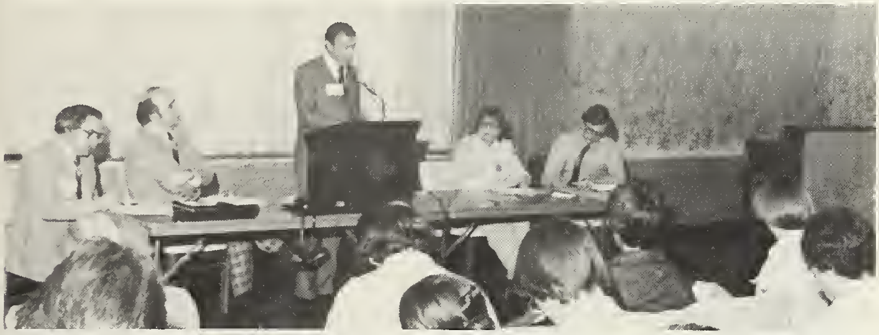
One of a series of annual journalism workshops, it served as a primer for student journalists and a forum for working journalists and health professionals. Topics of the two panels on the program were "Identifying Current Health Issues" and "Sources for Medical Reporters."

Journalistic advice

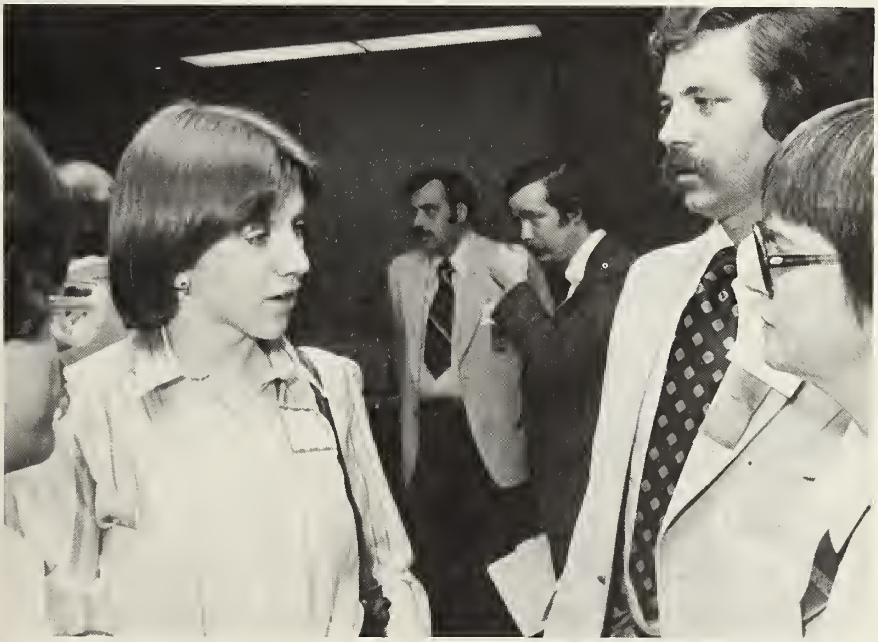
Steve Cain, investigative reporter with the Detroit News, noted that "when we do the traditional journalistic thing, we follow their (medical profession's) agenda." He stressed digging deeply into issues.

"Know your sources," warned Jane Haradine, a Grand Rapids Press medical writer who is also a registered nurse. "Know which you can trust and which ones will fog the issue."

Michael Killian, public relations coordinator for the Michigan Hospital Association, said a good information officer will expect a journalist to be skeptical. Their job, he said, is to get reporters information that is accurate and that can be used for a fair, balanced story.



Speakers at the morning session included, from left, Robert J. Toteff, MD, Saginaw family physician, Merwyn G. Scholten, MSMS media relations director; Robert D. Burton, MD, Grand Rapids otolaryngologist, Jane Haradine, medical reporter for the Grand Rapids *Press*, and Steve Cain, *Detroit News* medical reporter.



When MSMS and Michigan State University co-sponsored a working seminar for MSU journalism students, the young people got together with Dan Koger of the Lansing Booth Newspapers bureau, second from right, and Ms. Haradine.

Students, reporters, public relations people, and health care officials turned out for the seminar, to help the students get a better view of current issues and learn more about covering the health care beat. The crowd numbered approximately 150 persons.

"That runs contrary to the working definition of a PR person, which is to change attitudes," said Killian. Changing attitudes based on facts is the important thing, he stated.

Sources of medical story ideas can be as casual as office conversation, Jensen suggested. He related his experience in probing the medical malpractice insurance issue ahead of many other reporters, after learning from a colleague that the malpractice insurance premium for her father, a surgeon, had skyrocketed.

He also warned reporters to "keep in mind the consequences of their stories," noting that stories about cancer research can bring false hope to those desperately ill.

Daniel Koger, a Booth Newspapers reporter, emphasized the importance of asking questions, and brought his point home by asking the student journalists to explain what a "CAT scanner" is. CAT scanner refers to "computerized axial tomography," a new type of diagnostic tool, which had been mentioned, but not defined, by earlier speakers.

Physicians precise

Aiming his comments at the student journalists, Koger said that physicians are "very precise" and "sensitive" about news stories that include their names.

"They are going to be evaluating your credibility, as are hospital PR people, nurses and editors."

The program concluded with a "news conference," primarily for the benefit of student journalists, with Vernon Bass, MD, then MSMS president. The student questions dealt with the use of life support systems, when life begins and ends, free determination, public financing of abortion and health maintenance organizations.

About 200 persons, including journalism students from Central Michigan University, attended.

The MSMS Committee on Public Service is hoping to promote similar seminars at other Michigan schools, according to chairman Thomas C. Payne, MD, Lansing, who welcomed the MSU students to the April seminar.

First UP med students graduate

A special convocation on May 22 honored the first medical students to complete MD training in Michigan's Upper Peninsula Medical Education Program.

The innovative project, designed to train primary care physicians in locations remote from campus, is under the direction of Michigan State University's College of Human Medicine and the Upper Peninsula Health Education Corporation.

The first graduates — nine men and one woman — received their doctor of medicine degrees at MSU winter term commencement exercises on the East Lansing campus.

The new MDs, who began their medical studies in 1974, will be taking internship and residency training next. All 10 are planning to practice in rural areas or small towns, seven in the Upper Peninsula.

In January 1977 the second class of 10 students launched its medical studies in Escanaba.

Top goal of the UP training program is to help alleviate geographic and specialty maldistribution of physicians Funding has come from federal and State of Michigan agencies, and the W. K. Kellogg Foundation.

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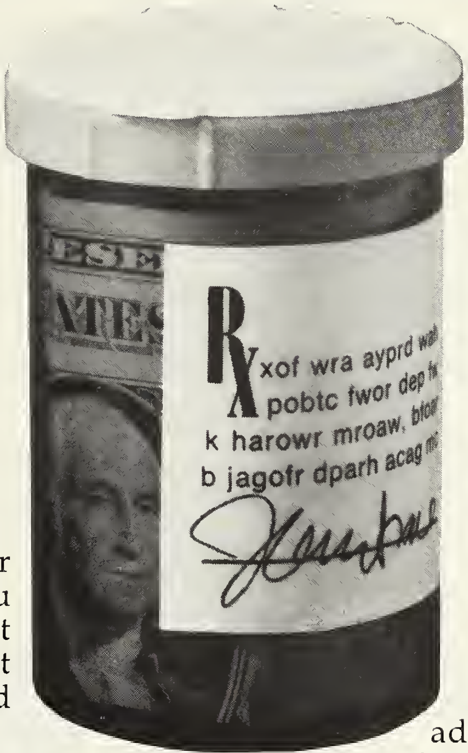

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Saginaw, Martin Peckover
501 Lapeer Street
(517) 776-6290

Traverse City, Scot MacDonald
10850 Traverse Highway
(616) 941-0111

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Robert B. Baker, MD
132 W. Van Buren
Battle Creek 49016

Thomas R. Buroker, DO
1041 Harvard
Grosse Pte. Park 48236

Luis E. Bustos, MD
18161 W. 13 Mile Rd.
Southfield 48076

Robert B. Bux, MD
615 Locust
Big Rapids 49307

Kin Chung Chan, MD
5639 Gateshead
Detroit 48236

Hubert W. Chang, MD
14937 Stoneham
Riverview 48192

Moo Hum Chung, MD
197 N. Washington Ave.
Battle Creek 49016

Ralph R. Cook, MD
2030 Dow Center
Midland 48640

Keith L. Curtis, MD
24631 Walden Rd., E.
Southfield 48075

Elvira D. Garner, MD
3150 Enterprise Dr.
Saginaw 48603

James A. Geissler, MD
2727 DeHoop, SW
Grand Rapids 49509

Jose Goldman, MD
Henry Ford Hospital
Detroit 48202

Mahmood A. Hai, MD
827 Charlesworth
Dearborn Heights 48127

Kathleen M. Harms, MD
1375 N. Main St.
Lapeer 48446

Mahmoud I. Haydar, MD
3710 Sunridge Dr.
Flint 48506

M. G. Sarath Hemachandra, MD
720 W. Ann Arbor Trail
Plymouth 48170

Thomas W. Henderson, MD
4142 Morton Lane
Stevensville 49127

Kang Nan Hsu, MD
1016 Long Lake Dr.
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Go ahead. Mix business with pleasure. Plan your next meeting or convention in Flint. For more information call toll-free 800/482-0989.

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22122 W. Nine Mile Rd.
Southfield 48034

Choong-Man Kim, MD
110 Orchard Dr.
Berrien Springs 49103

Gregory P. Lambourne, MD
112 E. John St.
Lake City 49651

Andrew W. Latham, MD
Burns Clinic Medical Ctr.
Petoskey 49770

Richard L. London, MD
506 Dodge
Houghton 49931

Daniel F. McDonnell, MD
Burns Clinic Medical Ctr.
Petoskey 49770

Manhar R. Mehta, MD
720 W. Michigan #203B
Jackson 49201

Robert A. Minuth, MD
100 15th St.
Bay City 48706

Mansoor G. Naini, MD
17300 Whitcomb #124
Detroit 48235

Nan Salman T. Najar, MD
29460 Springhill
Southfield 48075

Alan D. Neiberg, MD
2909 E. Grand River Ave.
Lansing 48912

Carolina P. Pareja, MD
20411 W. 12 Mile Rd.
Southfield 48076

Dale C. Peerbolte, MD
615 Douglas Ave. I-2
Holland 49423

Ruben Preide, MD
67 Cass Ave. #311
Mt. Clemens 48043

Tushar N. Raiji, MD
1222 Vincent Ct. #10
Flint 48503

Usha Ramakrishnaiah, MD
270 Lake Shore Dr. #405
St. Joseph 49085

Terrance A. Robinson, MD
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Adrian 49221

Marsha M. Rohrer, MD
1222 E. Michigan Ave.
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2765 Flushing Rd. #214
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K. M. Vander Velde, Jr., MD
506 Bronson Medical Ctr.
Kalamazoo 49007

Bernard M. Veenstra, MD
1310 Wisconsin Ave.
Grand Haven 49417

Gregg B. Wickstrom, MD
217 S. Madison
Traverse City 49684

(The following list was developed from members who joined MSMS in early spring.)

John R. Addy, MD
1846 Mayberry, SE
Grand Rapids 49508

Avery J. Aten, MD
324 Rosewood, SE
Grand Rapids 49506

Norma M. Carzon, MD
718 N. Macomb
Monroe 48161

Robert C. Clouse, MD
230 W. Oak
Fremont 49412

Barton L. Comstock, MD
2 Hospital Drive
Berrien Center 49102

Michael T. Connor, MD
Doctors Park #105
Escanaba 49829

Keith H. Crane, MD
1501 Hazen, SE
Grand Rapids 49507

William J. DeMots, MD
Mill Rd.
Adrian 49221

Charles W. Dunn, MD
Newberry Regional Mental Hlth. Ctr.
Newberry 49868

Krishne N. Gowda, MD
2550 Niles Rd.
St. Joseph 49085

Ahmad Hadied, MD
16185 Carriage Lamp Dr. #626
Southfield 48075

Myung-Ho Hahn, MD
1210 W. Saginaw
Lansing 48915

Thienchai Jayasvasti, MD
200 Jefferson Ave., SE
Grand Rapids 49503

Frederick A. Johansen, MD
2 Hospital Dr.
Berrien Center 49102

Marlen F. Junck, MD
255 Greenwood
Holland 49423

Jaya M. Lalji, MD
8420 Hall Rd.
Utica 48087

Allan R. LeReau, MD
517 Pleasant Ave.
Kalamazoo 49008

Jane Ann M. Mailloux, MD
712 Linwood Dr.
Midland 48640

Mukhtar A. Malik, MD
27117 Evelyn Ave.
Trenton 48183

Joseph M. Manoharan, MD
8447 Holly Rd.
Grand Blanc 48439

William R. Maurer, Jr., MD
9880 E. Michigan
Galesburg 49053

Alasdair I. McKendrick, MD
14901 W. 9 Mile Rd.
Southfield 48075

Edw. E. Mahrabian, MD
2959 Crooks Rd.
Troy 48084

G. Robert Miller, MD
Traverse City State Hospital, Box C
Traverse City 49783

Robert W. Miner, MD
6850 Division Ave., S
Grand Rapids 49508

Roger H. Morris, MD
23778 W. Warren #4
Dearborn Heights 48127

Dale M. Plapp, MD
315 Maple Street
Saugatuck 49453

N. V. Rao, MD
1011 Patrick #19
Flint 48503

Khawaja H. Rehman, MD
456 Cross St.
Hudson 49247

Alexander H. Sackeyfio, MD
2793 Farmingdale
Birmingham 48010

Joel R. Saper, MD
3636 Middleton
Ann Arbor 48105

Richard A. Simms, MD
175 College St.
Battle Creek 48017

Carlos R. Torres, MD
205 N. Scott C-1
St. Johns 48879

Pankaj N. Vakharia, MD
G5285 W. Pierson Rd.
Flushing 48433

Daniel J. Verburg, MD
Burns Clinic Medical Ctr.
Petoskey 49770

James D. Webb, MD
4685 S. Luce
Fremont 49412

Francis P. Welsh, MD
1414 W. Fair Ave.
Marquette 49855

Paul R. Williams, MD
Wm. Beaumont Hosp. Dept. of Neonatology
Royal Oak 48072

S. John Yu, MD
1407 Center Ave.
Bay City 48706

Ivars Zadvinskis, MD
4236 Kalamazoo Ave.
Grand Rapids 49508

Congratulations to Michigan Medicine!

My congratulations to you and your associates on the award you have earned for *Michigan Medicine*.

I know you will continue to perform in at least the same exemplary manner and earn many other awards.

Louis E. Heideman, M.D.
President
Michigan State Medical Society

* * *

Hurray, hurray for MICHIGAN MEDICINE! Your Sandoz prize is *great*. You certainly had it coming to you.

Cheers,

Ann Gray
Managing editor
Virginia Medical

* * *

Congratulations! It was great to read that you were the recipient of FIRST PRIZE from Sandoz Pharmaceuticals. Keep up the GOOD WORK!

Miriam Polich
Executive Vice President
State Journal Group
Oak Park, Il.

* * *

The other day I noticed in the news letter, "Medical Journalism," which is published by Sandoz Pharmaceutical that your Journal, *Michigan Medicine* was a first prize recipient in the Sandoz Journalism Awards competition.

I think that this is a tremendous accomplishment on your part and wanted to take this opportunity and congratulate you on your success. I guess this goes to show you that new and innovative ideas do pay off. Now, when individuals question you on why your medical journal no longer includes clinical and scientific articles you can inform them of your readership survey results and then point to your first place plaque, which more than proves the reason behind your reorganization of your journal.

Joseph A. Witherington, Jr.
Managing Editor
Kentucky Medical Association Medical Journal

* * *

Having received the May issue of *Medical Journalism*, I wish to congratulate you on your first place standing for your newsletter, *Michigan Medicine*!

As Executive Secretary of the Bibb County Medical Society, I am in charge of our own publication and am eager to find ways of improving it. I would very much appreciate a copy of your paper to see what exactly goes into an award-winning newsletter.

Once again, congratulations on your achievement and best wishes for future success.

Kyla K. Connor
Executive Secretary
Bibb County Medical Society
Macon, Georgia

Thank you for tax limit information

Having just picked up my Michigan Medigram of 5/16/78, I wish to extend my appreciation for the follow-up and for the inclusion of the tax limitation information in the Medigram.

I write this letter, because as you know I wrote about a week or 10 days ago requesting that you consider doing that, and I see that it had gone through the process and I am most happy and most appreciative and very proud of the MSMS for providing that service in this era of too much government.

W. C. Averill III, M.D.
Saginaw

Nursing home reform group seeks physicians' cooperation

The National Citizens' Coalition for Nursing Home Reform represents individuals and groups working in communities around the country to improve conditions for nursing home residents.

On February 5, 1978, the Coalition's Steering Committee met with several high ranking HEW officials to communicate important issues of concern to its membership. During that meeting, the Committee presented its first working paper, "The Plight of the Nurses Aide in America's Nursing Homes: An Obstacle to Quality Care for Nursing Home Residents." This paper discusses one major concern of the Coalition: There is too often inadequate training, experience and supervision of the aides and orderlies who deliver most of the day to day care to nursing home residents.

Your organization, representative of health care professionals, most likely shares our concern.

Citizens and professionals working together can certainly reach the goal of having trained, experienced personnel delivering care to nursing home residents. We encourage your support and direct action on this issue.

We would appreciate any suggestions or comments from your membership, since the working paper on this issue will be revised and strengthened as new information requires and resources permit.

If you have any questions, please let us know. Thank you for your consideration.

Elma L. Griesel
Program Coordinator
National Citizens' Coalition for Nursing Home Reform
Washington, D.C.

Manner in which arbitration offered key to its public acceptance

(The following article summarizes the official audit conducted recently of the Michigan medical arbitration system. The auditors were under contract to the Michigan Insurance Bureau and the Michigan Arbitration Advisory Committee. Just the conclusions of the full hospital audit report, completed this spring, are presented here. HMOs, sanitariums and free-standing surgical outpatient facilities also were audited. Further information is available from William E. Madigan, MSMS headquarters.)

The audit this year demonstrates all sample hospitals have implemented the arbitration program by organizing systems for offering the arbitration option to patients. One of the hospitals surveyed implemented the arbitration program even though it is self-insured and thus not required by law to participate.

The arbitration program is working with various levels of success. Hospitals in the Detroit metropolitan area are offering the arbitration option to their patients with less success than state hospitals. The main difference between the two groups appears to be the amount of personnel time set the amount of personnel time set aside for in-hospital follow-up programs. The difference between the rate nursing staff rather than clerical staff was not significant. The main factor involved with regard to the rate of success depended on the administrative commitment to allocate staff resources to the arbitration program.

Systems vary

As was found in last year's audit, the system for offering the arbitration option varied according to hospital departments. In-patient departments showed the highest rate of offering the arbitration option.

However, last year's audit showed outpatient departments had the highest rate of offers. The audit of outpatient departments of the majority of hospitals examined this year revealed hospital staffs were not repeating offers to patients on later visits who had declined the first offer. Those hospitals considered a refusal of the arbitration option to be valid for one year. The examiner pointed out to those hospitals this procedure is incorrect.

In agreement with last year's audit was the finding that emergency rooms throughout the state offer the option at a significantly lower rate in comparison with the other departments.

The higher rate of success in presenting the option to inpatients may be explained by the fact the hospital has time for follow-up on missed patients. Generally, all hospitals offer the arbitration option to inpatients as they register to be admitted. Along with other documents hospitals present to patients, the arbitration agreement is offered.

The requirement that emergency room patients be offered the option after treatment makes a follow-up program in the emergency room essential. Mailing the forms to emergency room patients is an expensive and not particularly effective method of reaching patients. Three hospitals utilized the nursing staff. After the patient has seen a physician, a nurse sees the patient to ensure the patient understands the physician's instructions. At that time the nurse also offers the emergency room patient the arbitration option. This has proven to be one very successful method of offering the arbitration option to emergency room patients. Most sampled hospitals, however, have assigned emergency room clerical personnel to present the option.

Claim experience of Michigan Medical Arbitration System as of May 31, 1978

37 cases filed to date
11 filed against hospital only
19 filed against both hospital and doctor
7 filed against doctor only
21 cases filed over incidents in outstate area
16 cases filed over incidents in Detroit-Macomb-Oakland area
26 cases filed by attorneys for the claimants
11 cases filed by claimants themselves

8 closed cases
3 cases settled (settled out of arbitration)
4 cases withdrawn (agreed upon by both claimant and defendant)
1 case awarded

29 pending

—William E. Madigan, Chief
MSMS Bureau of Negotiation

Attitudes influence

The audit examination indicates when patients are presented the option to sign the agreement, over 60% sign it. One reason for the figure not being higher may be the negative attitude of some hospital personnel toward the program. Arbitration is designed to provide a technique for early resolution of malpractice claims and a reduction in lawsuits. It is important Michigan citizens be presented with the agreement in a neutral manner. The negative attitude of some hospital personnel may tend to deter patients from signing.

The number of patients revoking the agreement is very low. There appears to be evidence some patients revoke the agreement because they perceive a problem with the medical treatment they receive. This is one way for the hospital administration to be aware of a possible future malpractice claim.

Precise costs of the arbitration program could not be assessed through this examination. An average estimated cost of the sampled hospitals was 36 cents per patient. The evaluation of the arbitration program being conducted by the Arthur Young & Company should provide more precise costs next year.

The audit examination results show four hospitals are currently violating the statute. The documentation of alleged offers is suspect. The greatest problem occurs in the emergency room where many patients are not offered the option.

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- Vasodilan—compatible with your total regimen for vascular insufficiency

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Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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CME Programming Committee plans MSMS courses

Charles Maclean, PhD, has the undivided attention of fellow members of the CME Programming Committee as he reviews plans for the Michigan Psychiatric Society's weekend seminar on the medical marriages, co-sponsored by MSMS for Category I Credit.

Chairman Carl Hammerstrom, MD, Marquette, right center, guides the CME Programming Committee through a lengthy agenda, assisted by MSMS Deputy Director Herbert Auer.

MPB liaison committee tackles PA rules

Regulations governing what physicians' assistants can and can't do are being developed by the MSMS Liaison Committee with the Medical Practice Board and board members themselves. In the meantime, legislation to set the rules in law is stalled in the legislative process awaiting the committees' and boards' compromise language.

The MSMS Liaison Committee asked The Council March 8 to approve several recommendations for amending the proposed rules and regulations governing PAs. The Council referred those amendments back to the committee for further work with the Medical Practice Board.

Committee members are working specifically on language that will set clear PA guidelines for prescribing legend drugs, restricting them from performing certain surgical procedures, and limiting delegation of diagnostic and treatment authority to PAs.

The Medical Practice Board's proposed rules have met with political and legislative opposition in four main areas which are the subject of the above recommendations. The legislature has extended its deadlines for the rules to be approved by the Joint Committee on Administrative Rules.

Ernest P. Griffin, Jr., MD, Flint radiologist, was elected MSMS president-elect during the 1978 MSMS House of Delegates meeting.

Photo highlights: 1978 MSMS House of Delegates

Louis E. Heideman, MD, Birmingham, r
received the MSMS silver mantle on hi
stallation as 1978-79 MSMS president. N
ing the presentation was Vernon V. Bass,
Saginaw, left, 1977-78 president. Bear
approval is James D. Fryfogle, MD, Sc
field, speaker of the MSMS House. The m
tle is engraved with the names of all fo
MSMS presidents, and their terms of offi

Doctor Heideman took the oath of office under the direction of MSMS Secretary Kenneth H. Johnson, MD, Lansing.

er Griffin, Flint attorney and son of MSMS
ident-elect Doctor Griffin, graciously acknow-
ed his father's election before the House of Dele-
. Doctor Griffin was unable to attend the an-
meeting. Quips were heard that this was the
time in MSMS history that an attorney had ac-
ed the presidency of the state medical society.

Louis R. Zako, MD, Dearborn Heights, left, was elected to replace Doctor Griffin as chairman of the MSMS Council. Doctor Zako has served two years as vice chairman. Selected new vice chairman is James H. Tisdel, MD, Port Huron, also chairman of the MSMS Committee on Publications.

Pins were presented to the 50-year doctors during House of Delegates ceremonies.

MSMS President Vernon V. Bass, MD, left, welcomed MSMS 50-year awardees special luncheon in their honor during the House of Delegates meeting. An them were Gunther E. Tiedke, MD, Saginaw, and Mrs. Tiedke. Each of the hono is an MSMS member who graduated 50 years ago from medical school.

All resolutions submitted to the MSMS delegates were first debated by reference committees during open hearings. MSMS policy on cost control was recommended by this committee, led by Frank B. Walker, II, MD, Detroit, third from left. Also on the committee, from left, were Jack L. Barry, MD, Saginaw; James M. Grost, MD, St. Johns; Paul D. Croissant, MD, Bloomfield Hills; S. Newton Kelso, MD, Monroe, and George M. Wilson Jr., MD, Marquette.

A special event of the House of Delegates meeting was the annual MDPAC luncheon, which featured legislators as speakers. Gathered following the luncheon were, from left, MSMS Speaker of the House James D. Fryfogle, MD, Southfield; State Sen. Jerome T. Hart, Saginaw; Willah Weddon, Stockbridge, president, MSMS Auxiliary; Louis E. Heideman, MD, 1978-79 MSMS president, and Jean Bass, wife of 1977-78 MSMS President Vernon V. Bass, MD.

nal health planning as it will affect Michigan physicians was discussed by ed panel of experts during a special House of Delegates forum.

ognition also went to:

SIEGEL
JOHN

rt J. Priest, MD, President
us International Society of
roenterology

Bernard M. Schuman, MD, President
American Society of Gastrointestinal
Endoscopy

l C. Hayden, MD, President
igan Association for Better Hear-
nd Speech

Arthur H. Ulmer, MD, President
Michigan Division, American Cancer
Society

An MSMS Presidential Citation was presented to Maurice S. Reizen, MD, director, Michigan Department of Public Health, by Doctor Bass. Doctor Reizen was cited for "his unique ability to blend the best in medical care with a warmth and human understanding of the problems and issues." He was praised as "an able scientist and administrator, and a respected doctor of medicine.

Views

Physicians and nurses planning together will best promote welfare of the patient

This article is presented on an exchange arrangement with the Michigan Nurses Association, which this month is publishing an article written by Louis E. Heideman, MD, MSMS president, in Michigan Nurse.

By Ann M. Zuzich, RN
Detroit

Significant improvement in the quality of health care delivered to the public can be achieved through more effective collaboration between physicians and nurses.

The historic image of the paternalistic physician and his (almost never her) obedient, unquestioning nurse (almost always female) has vanished; the winds of change have certainly included the changing role of women, but there were other factors, too. The expanding needs of a technologically sophisticated society have created demands on health care providers that are reflected in an ever-increasing number of varied, highly skilled practitioners whose emergence has complicated the heretofore simple nurse-doctor alliance.

In addition, there is an increasing number of persons in our society who have been able to learn many things about their bodies and how to keep them healthy; the expectations of the health care provider are quite different now than a generation ago. To continue to remain responsive to the demands of the public, both the nursing profession and the medical profession have found it necessary to modify the system and content of educational preparation and the means of assuring competence of their respective practitioners. Along with many other health care professions, nursing has engaged in continuous efforts to refine the essence of its practice and to effectively articulate its meaning.

Nurse accumulates data

Henderson has provided a widely accepted definition of nursing: "Nursing is assisting the individual (sick or well) in the performance of those activities contributing to health, or to its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. It is likewise the unique contribution of nursing to help the individual to be independent of such assistance as soon as possible." (Harmer, 1955, p. 4)

It is obvious that to assist the recipient of care to effectively perform activities contributing to his/her health necessitates not only an understanding of the health status of the individual, but an understanding of the psycho-social factors which contribute to the individual's behavior. The use of the nursing process provides the professional nurse with an accumulation of data gathered through continuous assessment of the individual.

It is with this data that the professional nursing practitioner decides upon a plan of action collaboratively with the individual and other members of the health care team. The necessity for collaborative action is crucial, if smooth and efficient progress is to occur toward mutually agreed upon goals.

The role of patient advocate is one that nurses can and do fulfill very well; it is closely related to the intimacy of the relationship which is inevitable in "acting and interacting with the patient through physical and personal contact for his welfare, and intervening in his behalf between him and those stresses in the physical environment and in the social climate that impinge on him."

Communication skills are basic to nursing; these are important tools in the development of the relationship necessary for the provision of nursing care. Knowledge of the teaching and learning process is vital in practicing professional nursing, to help the individual move toward independence of assistance. Techniques of counseling are valuable skills that permit nursing practitioners to effectively respond to troubled individuals seeking assistance through the intimate relationship established with the nurse. Techniques of evaluating health are a significant part of nursing skill, becoming more and more refined.

All of the aforementioned components of the role of nursing emerge from the professional nurse's educational preparation which is lengthy and difficult; it provides competent practitioners who often pursue higher degrees in nursing, some to

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Mrs. Zuzich is president of the Michigan Nurses Association.

Mrs. Zuzich

the terminal degree of Doctor of Philosophy in Nursing. Nursing research continues to expand under the direction of nurse researchers; a theoretical base and directions for improving practice are expanding.

More collaboration needed

The physician responsible for the medical care of the individual, and the well-prepared professional nurse collaborating with each other and with the patient, have the potential for increased efficiency and improved quality of care.

The professional nurse will have opportunities for the collection of data in the nursing assessment, when added to the data collected by the physician and/or the physician assistant. This provides a more comprehensive base for the collaborative planning of care. The incidence of inappropriate treatment based on inadequate data could be reduced.

Joint planning between physician and professional nurse will utilize the expertise of both physician and nurse to promote the welfare of the patient. The observation-judgment of the professional nurse about the condition of the patient always has been valued by the physician who often formulates decisions based on those judgments. Isn't there something to be gained by making that communication a two-way process? The contribution of the professional nurse is significantly increased in value if the physician is able and willing to share the possible decisions in considering new information about the patient's condition. Again, the nurse's intimate knowledge of the patient will provide a more comprehensive base for effective treatment decision-making.

The kind of collaboration that has been described can only occur in an atmosphere of respect and trust, and a measure of self-confidence that will permit sharing without feeling a sense of threatened self-esteem. Practitioners from any discipline develop that kind of self-confidence with continued practice; beginning practitioners will often demonstrate some insecurity, and their more experienced colleagues owe them support as they move toward professional competence.

Physicians must be selfish with statutes defining medicine

By Archie M. Bedell, MD
Detroit

The Medical Practice Act (PA 185, Section 2) defines the "practice of medicine," or "to practice medicine," as "to diagnose, treat, prevent, cure or relieve a human disease, ailment, defect, complaint or other condition, whether physical or mental by attendance or advice, or by a device, diagnostic test or other means, or to offer, undertake, attempt to do, or hold oneself out, as able to do any of these acts."

But now there is a need for a better definition with the existence of physicians' assistants, nurse health clinicians and nurse health practitioners.

There is great doubt in minds of many practitioners regarding role delineation between MDs and supervised, approved, certified physician assistants, and other health extenders. Medical schools stress differential diagnosis and treatment of patients, and emphasize the physician be trained as a thinker, a detective, a scientist, a problem-solver, a diagnostician, and not as a technician.

Physician should diagnose

The area of diagnostics and therapeutics should remain the physician's private domain.

The final diagnosis, and the decision of a treatment plan, should not be delegated to a physician's assistant, nurse health clinician, or nurse practitioner. This is in the best interests of the patient's safety, and if controlled totally by the physician, the health care extender would provide quality care under the direction of the physician.

The watchword of the practice of medicine, as perceived by the public, is "quality" care, and this guarantee rests truly in the ability of the physician to diagnose and treat his patients, utilizing the most advanced forms of diagnostic methodology and treatment modes that are currently available. This is no task for anyone less trained.

We must be 'selfish'

Therefore, we, as physicians, should be concerned with further defining the practice of medicine, and should selfishly control the role of diagnosis and treatment, under absolute control of supervising physicians, as carefully defined in PA 185.

Furthermore, we, collectively, should take the time to further delineate the so-called privileges of the delegated acts segment of PA 185 that we desire regarding all of our assistants.

I would hope all of us, as interested, dedicated practitioners of medicine, would feel selfish about the privilege of diagnosis and treatment. It should remain totally under the jurisdiction and supervisory control of actively practicing physicians.

Your Medical Practice Board needs guidance and support, if this be your desire.

Doctor Bedell is a Detroit-area family physician and is a member of the MSMS Committee on Public Service.

Doctor Bedell

Let us hope physicians don't permit mediocrities of socialized medicine

By James J. Coury, MD
Port Huron

When the opportunity came to go to England to view the British Health Service, I truthfully went to England with an open mind. I hoped to find something that would be constructive to bring back to our country.

I must say, however, after viewing the British Health Service, I returned disappointed and depressed. I will attempt to summarize this and keep it brief as I am sure many of the observers have the same feeling.

There is no question the British Health Service is a bureaucratic nightmare and administrator's playground. The patient ends up being the low man on the totem pole and the physician one rung above him. This problem appears to be compounding as evidenced by the fact that the administrators have increased 21 percent in number since 1974.

One hears so much today about the fact that our health care system consumes over eight percent of our gross national product whereas, in England, it only consumes approximately six percent. An interesting point, though, is that nursing home facilities in England are not considered an expense of the National Health Service but are under the aegis of the Social Service bureaucracy and considered "custodial care." If one would combine the "custodial care" with the National Health Service costs, I am sure the percentage of their gross national product for health care would equal that in the USA.

In talking to physicians and administrators of the National Health Service, I found socialized medicine has not resolved the distribution problem of provider services. In fact, nowhere in Western Europe where socialized medicine is most prevalent has distribution been resolved by having a socialized program. Some of the most impressive things that I perceived in England were:

1. Poor maintenance of health care facilities.

2. Inefficiency of the system in general.

3. Laissez-faire attitude of physicians and nurses.

4. Unlimited access but *limited* service.

5. Empty hospital beds as a result of limited service.

6. An absolute "cap" on health expenditures thereby limiting service and accentuating mediocrity.

7. The lack of queuing up for services — I expected to find long lines in the outpatient departments and doctors' offices but, for some unexplainable reason, these did not appear to exist.

8. The continual defensive position and statements by physicians and nurses for the British Health System while they complain bitterly of the fact that funds, facilities, equipment and personnel are inadequate to do the job that is needed.

9. There is less surgery done in Britain per thousand population than in the United States but this is because of limited funds and service and not because the surgery is not needed.

10. An active planning program exists in England but primarily to ration the delivery of health care.

11. An admission by physicians and nurses that the status of the professional is somewhere below the "locations of other domestic services."

12. Some of the facilities that we visited would have been closed by our state health department, fire marshals and other accrediting bodies for being unclean, unsafe and inadequate.

13. Considerable emphasis was placed on the fact that, to make the present system work, more voluntary non-paid organizations were necessary.

14. By 1980, there will be an over-abundance of physicians in the British Isles which will necessitate some physicians going on "the dole."

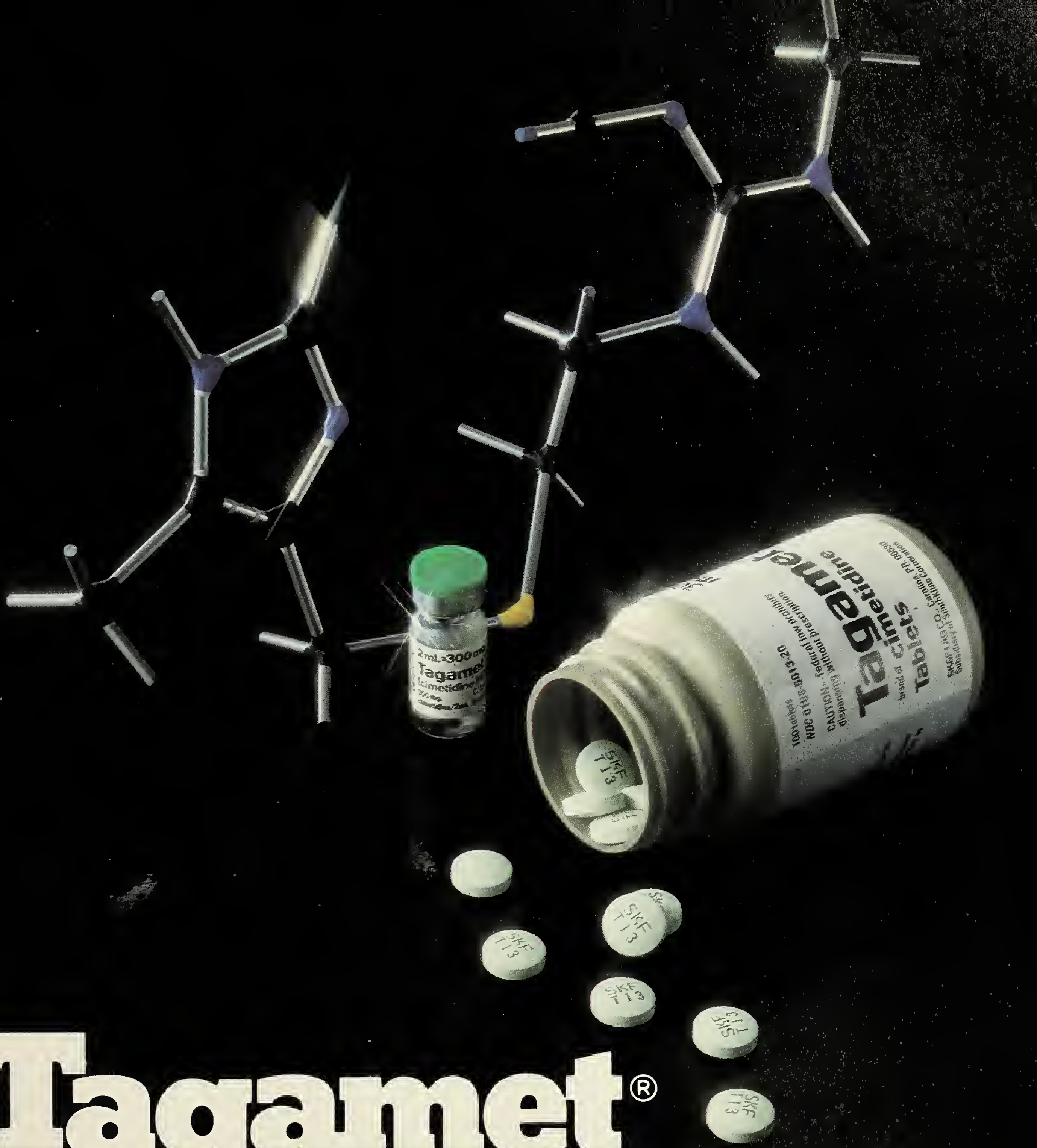
15. Disappointing defeatist attitude of many physicians — "It's here; it's underfinanced; it's not the type of care we would like for our patients; it's not the type of practice we care to do; our status has deteriorated but there is nothing much we can do."

16. If ever we could learn a lesson in American medicine, the present British Health Service is a great teacher for us.

I realize I am being very critical, not only of the British Health Service but of our British medical colleagues as well. It is important that organized medicine get its story, not only to the physicians of this country but to the public and legislators as well. We must do it in an intensive and urgent manner. If the physicians and the public of this country as well as our legislators could learn the true meaning and ramifications of socialized medicine, I am sure it could be avoided in this country. No way would American citizens stand for such mediocrity of medical care. I would hope the medical profession in this country would not permit such mediocrity.

Doctor Coury is an AMA trustee and is past president of MSMS.

Doctor Coury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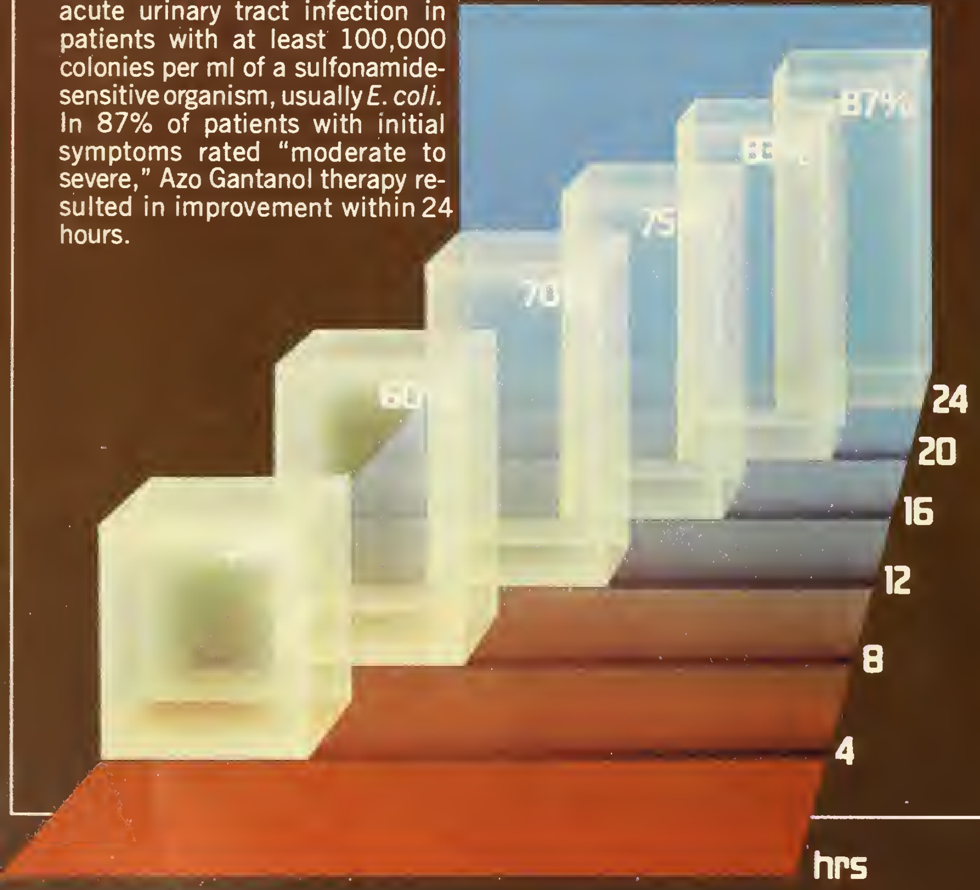

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Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term during nursing period; because Azo Gantanol tains phenazopyridine hydrochloride it is contr dicated in glomerulonephritis, severe hepatitis uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not establi Deaths from hypersensitivity reactions, agranu tosis, aplastic anemia and other blood dyscras have been reported and early clinical signs (so throat, fever, pallor, purpura or jaundice) may dicate serious blood disorders. Frequent CBC urinalysis with microscopic examination are re ommended during sulfonamide therapy.

Precautions: Use cautiously in patients with i paired renal or hepatic function, severe allerg bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria a stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia leukopenia, hemolytic anemia, purpura, hypo thrombinemia and methemoglobinemia); *aller reactions* (erythema multiforme, skin eruption Stevens-Johnson syndrome, epidermal necroly urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbita edema, conjunctival and scleral injection, pho sensitization, arthralgia and allergic myocardit *G.I. reactions* (nausea, emesis, abdominal pai hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, periphe neuritis, mental depression, convulsions, atax hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, tox nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certai chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hyp glycemic agents, sulfonamides have caused ra instances of goiter production, diuresis and hy glycemia. Cross-sensitivity with these agents m exist.

Dosage: Azo Gantanol is intended for the acute painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 G (2 tabs) B.I.D. for up to 3 days. If pain persist causes other than infection should be sought. After relief of pain has been obtained, continu treatment with Gantanol (sulfamethoxazole) m be considered.

NOTE: Patients should be told that the orange dye (phenazopyridine HCl) will color the urine.

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BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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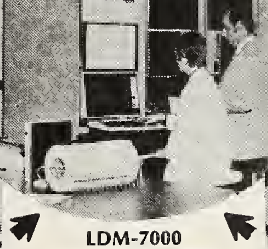
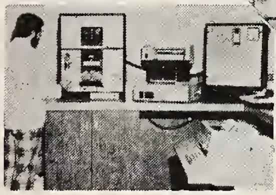


LDM-7000 Central processing unit



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LEM Automatic entry of differential count

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News

By Katie Brewbaker, MSMS Staff

Michigan physicians contributed prominently to AMA publications in May. **Lloyd J. Lemmen, MD**, Muskegon, wrote an article on "Intravenous Lidocaine in the Treatment of Convulsions" for the May 12 *JAMA*. Also appearing in this issue was an article on "Esophageal Leukoplakia: A Rare Entity" by Doctors **Barry R. Herschman, Varin Uppaputhangkule, Luis Maas**, and **Eugene Gelzayd**, of Southfield. Doctors Maas and Gelzayd also co-wrote, with **James K. Karo, MD**, and **Henry Kaine, MD**, "Ultrasonography and Parathyroid Adenoma" published in *JAMA*, May 19.

Medical Economics liberally quoted **Frederick W. VanDuyne, MD**, Flint, in its comprehensive May 1 article on medical costs entitled, "The Real World of Hospital Finance." Doctor VanDuyne is chairman of the MSMS Task Force on Medical Care Costs.

Doctor **Clara Raven's** presentation on crib deaths, delivered at the 1977 MSMS Annual Scientific Meeting last November, has been published in the *Journal of Forensic Sciences* under the title, "The Sudden Infant Death Syndrome (SIDS): A Possible Hypersensitivity Reaction Determined by Distribution of IgG in Lungs."

Irving I. Edgar, MD, Detroit, has written another new book. His latest contribution is "The Origins of the Healing Art: a Psycho-Evolutionary Approach to the History of Medicine," just released by Philosophical Library, Inc., of New York City. Other literary works of Doctor Edgar are "Shakespeare, Medicine, and Psychiatry," published in 1970, and "Essays in English Literature and History," 1972.

Gordon Heller, MD, director of Mercy Hospital's emergency service center in Muskegon, is recipient of an award from Muskegon Community College in recognition of his contribution to the emergency training program he directed at MCC.

Ethelene J. Crockett, MD, Detroit, is the first woman elected to serve as president of the American Lung Association. A gynecologist at Grace-Harper Hospitals, Doctor Crockett is assistant clinical professor of community medicine at WSU. In addition to her active role in community affairs and volunteer medical services, she has twice lectured on health care in Mainland China.

The head of Henry Ford Hospital's Division of Cardiovascular Medicine, **Sidney Goldstein, MD**, is chairman of a National Heart and Lung Disease Institute steering committee to test the effectiveness of propranolol, a drug for preventing sudden death or additional attacks in patients who have had an acute myocardial infarction.

William C. Grabb, MD, Ann Arbor, is new head of the University of Michigan Hospital section of plastic surgery. Known for his work in surgical repair of cleft lip and palate, Doctor Grabb has been acting director of the section since 1975.

Assuming the presidency of the Wayne State University School of Medicine's Alumni Association is **Richard G. Butler, MD**, Dearborn. Doctor Butler is chairman of the Department of Otolaryngology at Oakwood Hospital.

Herbert Sloan, MD, University of Michigan professor of surgery and head of the section on thoracic surgery, is newly elected vice president of the American Association of Thoracic Surgery. He previously served as president of the Society of Thoracic Surgeons.

Thomas M. Batchelor, MD, Detroit, is recipient of the Distinguished Alumni Service Award of the WSU School of Medicine and WSU Medical Alumni Association.

The Greater Michigan Foundation has cited **David Gilbert, MD**, of Laurium, for his "unselfish devotion to health care and education" when awarding him a Michigan Week Volunteer Leadership Award at a special program in Marshall on May 22.

John A. Rupke, MD, Kalamazoo, is new vice chairman of the AMA Commission on Emergency Medical Services.

Nearly 200 patients gave a special party for their physician and friend, **Shelby M. Baylis, MD**, Pontiac, upon his retirement from private practice to become medical director at General Motors Technical Center in Warren. It was their way of thanking him for his many years of service as a general surgeon, team physician for the Pontiac Central football team, and all around good friend.

The people of Iron Mountain aren't about to let the retirement of **Russell C. Retallack, MD**, go unnoticed after he's been their doctor for 37 years. They all got together for a recognition dinner in his honor on May 27 to express their appreciation.

Most people would think completing medical school, a residency in anesthesiology, and then maintaining an active medical practice would, in itself, be a worthy enough accomplishment. But, **John J. Kennedy, MD**, of Lansing, obviously feels that if one profession is great, two professions must be even better. He has just graduated from Cooley Law School, following in the footsteps of his father, a judge, and his brother, an attorney.

The Windsor Chamber of Commerce selected Lansing internist, **Richard C. Bates, MD**, as guest speaker for its recent 5th Annual Secretaries Luncheon. Three hundred and sixty Chamber members and their secretaries were entertained by Doctor Bates' informative, albeit humorous tongue-in-cheek, message on how to live a long and fruitful life.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Deaths

Thelma W. Campbell, MD
Encinitas, CA

Thelma W. Campbell, MD, Encinitas, Ca, who was a long-time Dearborn Heights pediatrician, died April 25 at the age of 72. Doctor Campbell, who led research in a milk-fortification process, received her medical degree from Western Reserve University Medical School. She was a member of the American Academy of Pediatrics, the Detroit Pediatric Society and the American Medical Women's Association. She was also a charter physician at Oakwood Hospital.

Corwin S. Clarke, MD
Carmel, CA

Corwin S. Clarke, MD, Carmel, CA, died April 28. A graduate of the University of Michigan Medical School, Doctor Clarke was past president of the Jackson County Medical Society, served several terms as a member of the MSMS House of Delegates, and was a fellow of the American College of Surgeons. He was past chief of staff and past chief of surgical staff at W. A. Foote Memorial Hospital, as well as a member of the surgical staff at Mercy Hospital.

Aleksandrs Kalnins, MD
Grand Rapids

Aleksandrs Kalnins, MD, Grand Rapids, died May 11 at the age of 83. Doctor Kalnins graduated from the University of Latvia, Riga.

John J. Kraus, MD
Detroit

John J. Kraus, MD, 68, Detroit, died May 29. A graduate of Wayne State University School of Medicine, Doctor Kraus was chief of surgery at Saratoga Hospital. He was a member of the International College of Surgeons.

Neal Moore, MD
Bay City

Neal Moore, MD, Bay City, died April 22 at age 74. Doctor Moore received his medical degree from the Jefferson Medical School, Philadelphia. He was a Bay area orthopedic surgeon and was chief of staff at General Hospital. He was also active in the Red Cross, was Bay County health director and its first medical examiner, and was director of the Bay Medical Care Facility. He was a team physician for Central High School and was a major in the Army Medical Corps during World War II.

Nimrod Sherman, MD
Detroit

Nimrod Sherman, MD, Detroit psychiatrist, died May 13 at 60 years of age. Doctor Sherman was a graduate of Wayne State University School of Medicine and served as a captain with the U.S. Army Medical Corps. He was a member of the American Psychiatric Association.

Clarence P. Truog, MD
Grand Rapids

Clarence P. Truog, MD, 76, Grand Rapids, died May 9. A radiology consultant on the Ferguson-Droste-Ferguson Hospital staff, Doctor Truog was a graduate of the University of Minnesota, where he was later an instructor. He taught and conducted research at the Mayo Clinic. He served on the staffs of Leila Post, Battle Creek and Ionia County Memorial hospitals. Doctor Truog was medical director of the National Ski Patrol.

Peter Ver Meulen, MD
Grandville

Peter Ver Meulen, MD, Grandville, died May 19 at the age of 92. Doctor Ver Meulen graduated from the University of Michigan Medical School and was affiliated with Youngstown Hospital, Ohio and Michigan Veterans Facility. The general practitioner was a member of the Academy of Tuberculosis Physicians and the American Trudeau Society.

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Gordon C. Dieterich, M.D.
Robert L. Fransway, M.D.
Sarah Hemachandra, M.D.
Carlos M. Lauchu, M.D.
Satya Pasricha, M.D.
Arcadio V. Ramirez, M.D.
Gerald M. Schmit, M.D.
Bruce D. Schweiger, M.D.
Joseph J. Tiziani, M.D.
Prehlad S. Vachher, M.D.
Angela Wallenbrock, M.D.
Richard D. Watkins, M.D.
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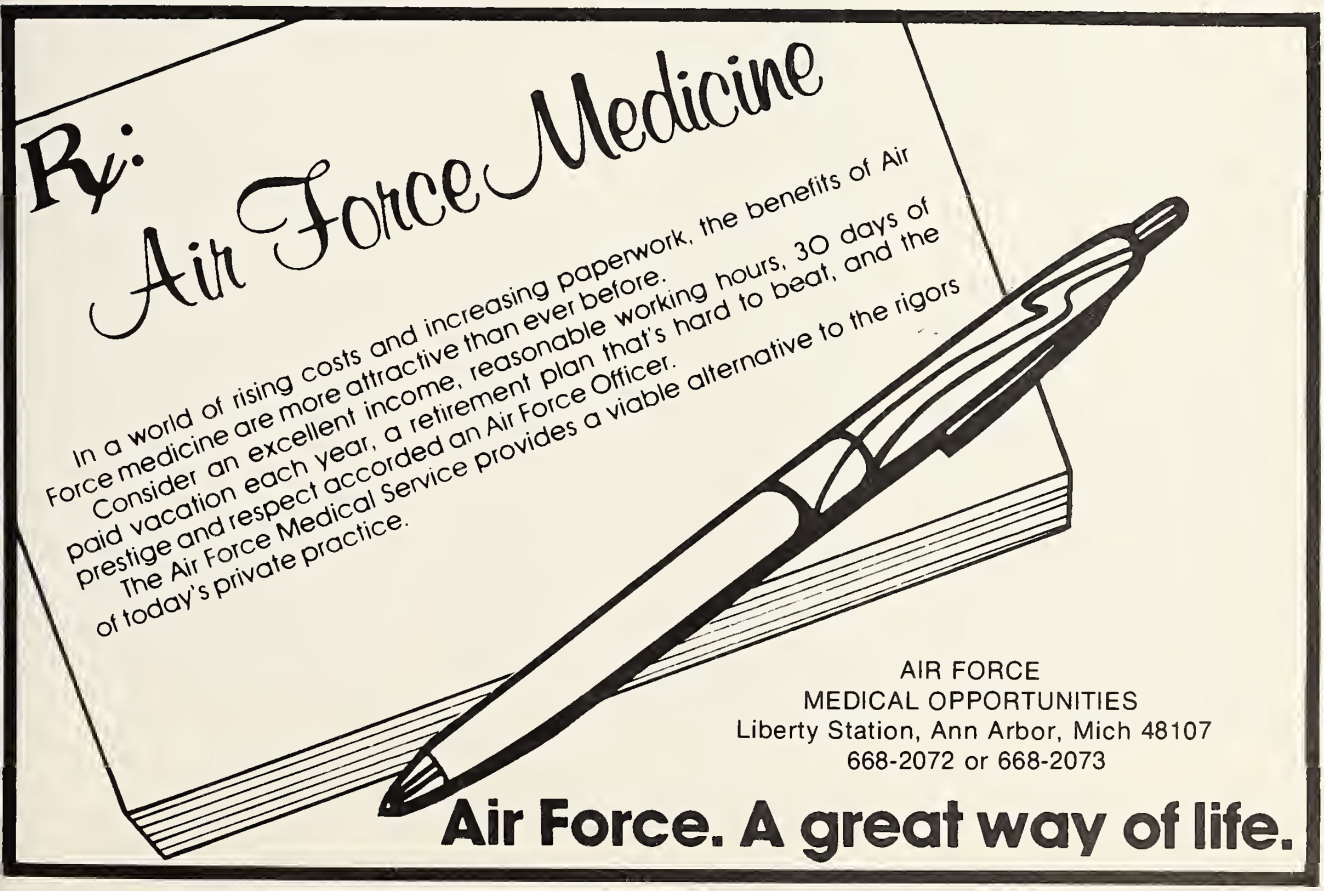

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THE CHILDREN'S LEUKEMIA FOUNDATION of Michigan (a United Way Agency) is interested in funding research in the general field of hematology (adults and children). The official grant proposal form must be used. The deadline for submission of requests is October 13, 1978. Questions regarding the above should be directed to: Arnold R. Axelrod, Chairman, Medical Advisory Board, Children's Leukemia Foundation of Michigan, Department of Medicine, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit, MI.

PSYCHIATRIST for established day hospital unit in general hospital psychiatry department offering full range of adult services. Must be Board certified or eligible, with administrative experience. Full time, salary competitive, liberal benefits. Contact: Norman Rosenzweig, MD, Sinai Hospital of Detroit, Department of Psychiatry, 6767 W. Outer Drive, Detroit, MI 48235, (phone: 313/493-6210).

WANTED: MEDICAL DIRECTOR for a plasma phoresis center; Monday, Tuesday, Thursday, Friday 9-5, Saturday 9-1. Full benefits. Will accept part time. Please contact Art Byrd at 313/487-3100. 309 Pearl Street, Ypsilanti, 48197.

MEDICAL HEALTH OFFICER (MD or DO, MPH) for single county health department to direct a staff of 130 with a budget of 2.8 million in a variety of programs excluding home health care. Salary negotiable. Send resume to Saginaw County Controller, 111 S. Michigan, Saginaw, MI 48602. An equal opportunity employer.

MICHIGAN — Active well-established large general practice, general surgery, in desirable recreational area, Northern Michigan. Excellent gross, modern equipment. Clinic bldg. with or without adjoining beautiful large home with lighted tennis court and swimming pool. Will lease or sell one or both. Favorable terms. Contact N. Lentini, MD, Lentini Medical Clinic, PC, 401 Elm Street, Cheboygan, MI 49721. 616/627-5656.

ORTHOPAEDIC SURGEON needed for Michigan city for modern progressive hospital; expansion underway; near state forests, Lake Michigan; rural setting minutes from major metro areas; recreational opportunities in a 4-seasons setting; excellent salary and fringe benefits. Reply Box 9, MSMS, 120 W. Saginaw, East Lansing, 48823.

PSYCHIATRIST WANTED for SW Michigan city for modern progressive hospital; expansion underway; near state forests, Lake Michigan; rural setting minutes from major metro areas; recreational opportunities in a 4-seasons setting; excellent salary and fringe benefits. Reply Box 10, MSMS, 120 W. Saginaw, East Lansing, 48823.

TWO PEDIATRICIANS needed in growing, young, Dutch community. Excellent opportunity for medical education, recreation and family life. Will help starting physician. Call Grand Rapids, MI, 9 to 11 p.m., 616/531-9803.

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FAMILY PRACTITIONERS, INTERNISTS, and/or OB-GYNs needed in growing, prosperous Dutch community to join a Board Certified family physician in existing practice, or solo available. Excellent economy with medical education, recreational lakes, and ski resorts within 20 mile radius. Will help solo practice to start out. Guarantee net income of $40,000 for first year partner. Call Grand Rapids, MI, 616/531-9803 between 9 and 11 p.m.

GENERAL PRACTITIONER — to provide medical care in a small state hospital for the mentally ill and mentally retarded located in Michigan's beautiful Upper Peninsula. Current salary $37,855 plus a liberal Civil Service benefit package. Write Steven A. Meyers, M.D., Chief of Clinical Affairs, Newberry Regional Mental Health Center, Newberry, MI 49868.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park, there are openings for physicians board qualified as internists, family physicians or psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently over forty thousand per year, plus fringe benefits, including life, accident, long term disability, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. No weekends or nights. 50

hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7789.

POSITIONS OPEN — New Lake Michigan professional building suites available adjacent to expanding community hospital. Especially desirable for family practitioner, pediatrician and pharmacy. South Haven, Michigan 49090. Call collect: David Fenske, MD, 616/637-5925.

Positions wanted

EXPERIENCED family physician, available for locum tenens work, during the summer, either in busy G.P. practice or Emergency Room. P. J. Greene, MD, 3875 E. Henrietta Road, Henrietta, NY 14467.

Miscellaneous

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FOR SALE — CUSTOM-BUILT HOME situated on approximately 40 acres of wooded land, river frontage, trout pond, three bedrooms, two baths. Many extras. An hour's drive north of Bay City. $85,000. 517/345-1571.

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Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the Five-week Period Ending June 2, 1978

	1978 This 5-Week Period	1977 Same 5-Week Period	1978 Total To Above Date	1977 Total Same Date	Total Cases for 1977
Rubella	815	150	1,902*	717	1,160
Cong. Rubella Syndrome	0	2	0	2	3
Measles	2,005	146	4,686*	770	1,392
Whooping Cough	2	1	8	14	73
Diphtheria	0	0	0	0	0
Mumps	281	305	1,083	1,458	2,339
Scarlet Fever & Strep Sore Throat	2,867	2,726	16,117	16,569	31,047
Tetanus	0	1	0	1	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	218	238	920	1,276	2,686
Salmonellosis (other than S. typhi)	66	80	359	371	989
Typhoid Fever (S. typhi)	0	2	4	9	13
Shigellosis	31	32	87	149	352
Aseptic Meningitis	7	6	32	31	207
Encephalitis	3	6	22	19	59
Meningococcic Meningitis	10	5	41	24	51
H. Influenzae Meningitis	22	21	58	64	151
Tuberculosis	138	111	531	593	1,279
Syphilis	117	96	472	499	1,151
Gonorrhea	3,221	3,349	13,239	13,577	36,883

Information can be supplied by the local health department on local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

*corrected totals

'You ain't seen nothin' yet!'

This being an election year, all kinds of zany things can be expected to emerge.

Combine this with suggestive evidence that the tide has turned for a national health insurance program — really a front for a national health system, and we can expect major attacks on the integrity of the medical profession and on individual physicians in the next few months exceeding anything we have encountered in the past.

As usual, these attacks will have a reality base, but will be distorted out of all reason, utilizing the techniques of the big lie, the demagogues, and the poison of the bigots. These are difficult to counter in that they are utilized at a critical time which precludes the preparation of an honest and effective response. They also have the element of sensationalism which appeals to editors, an appeal which rational response rarely has.

We will see efforts to nominate and elect individuals unalterably committed to a national health scheme. As part of this we will see an accentuation of the conflict around second surgical opinions, with inappropriate interpretations of whatever data are collected. We will see a number of lists published of fraud involving physicians as well as others. We will see the publication of long lists of the earnings of health professionals (with physicians predominating and claims that these constitute the largest number of services paid for by the government — services, not dollars). I expect that we will also see a larger volume of material published on acceptability of traditional medical services when provided by other categories of health professionals and paraprofessionals.

All of the fadists, movements and quack activities will be featured, often in the guise of "holistic health care."

Horrendous? But we can answer so long as we anticipate what can come, and prepare appropriately.

Some things can be done now, and some must be started now to reap the full benefits in the future. We must respond appropriately in the pattern of the scientific, rather than the adversary, approach. This must be done with full professional responsibility and dignity. A few of the things we can do include:

(1) Actively participating in the electoral process. It is too late to nominate candidates, but we can look for and contribute to the election of *responsible candidates*, even though they may not be in complete agreement with us on medical matters.

(2) Becoming active in the political arena as delegates and candidates at all levels of government. This takes time, but medicine is grossly underrepresented.

(3) Becoming knowledgeable about developing issues and informing our patients about them. We at MSMS will develop informative materials for our education and for presentation to our patients. Each of us wastes at least 10 minutes a day which could be most effectively utilized in discussion with just one patient. With the participation of each of our members, this would give us a potential exposure to 160,000 people per month. Assuming an average of 20 patient visits per day, we could expose well over a million (and probably approaching three million) people per month to our reasoned presentation. The potential of this should be self evident.

There is work to be done. We can do it. But we must do it with full awareness of what our patients want and expect, structuring our program for health services on this basis or educating them to the implications of current expectations.

Louis E. Heideman, MD
MSMS president

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE. Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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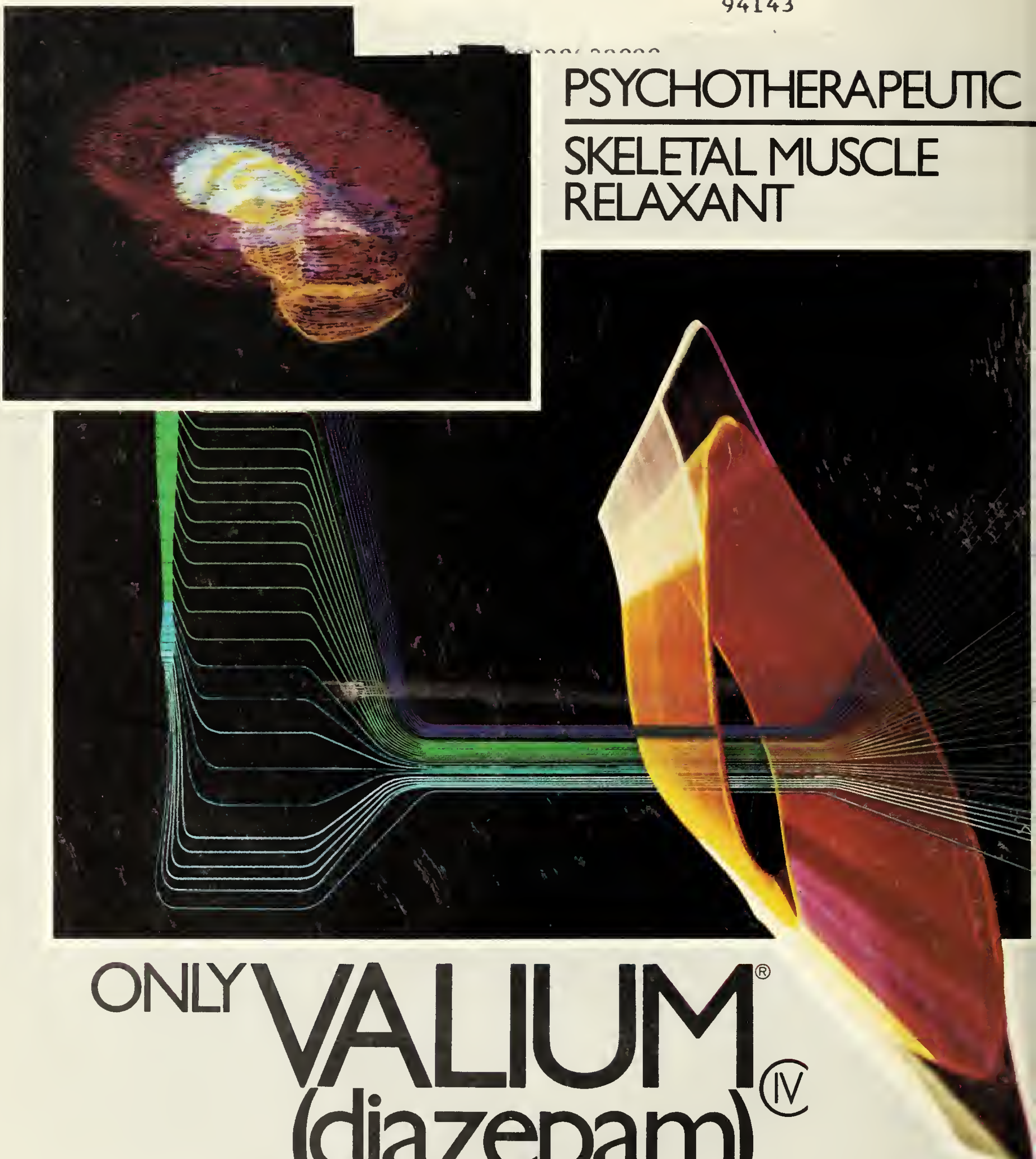

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MMENTARY--SECOND OPINIONS

The physicians of Michigan nd MSMS are concerned about e increasing cost of provid-ng health care and its impact n our total social structure," ouis R. Zako, MD, MSMS Council hairman, told the Michigan nsurance Commissioner in a ecent Lansing hearing.

octor Zako continued, "It ppears to us that our society s confused as to what it ants from our physicians. We re told to provide only those ervices which are absolutely ecessary.

We are criticized for being emote and impersonal and for ot spending enough time with ur patients, and we are at he same time criticized for ot being productive enough nd are told that we ought to elegate more responsibility o other less qualified per-onnel.

We are told to control our osts, and then are overwhelmed y demands for endless and re-etitive reports which increase ur office overhead and inter-ere with our ability to pro-ide service. We are told to ncrease our efficiency and roductivity, and then are in-olved in endless hours of eview, committee activity, nd planning.

The list could go on and on.

We would dearly like to be ncluded in a program for the stablishment of policy which ould delineate what is ex-ected of us and let us get on ith our basic responsibility--he improvement of the health f our patients."

SMS members may obtain a full opy of the MSMS statement (developed by Council Chairman ako and MSMS President Louis eideman, MD) by writing MSMS, ox 950, East Lansing, MI 48823.

BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine Medigram

VOL. 77, NO. 21 JULY 31, 1978

Blues, physicians making progress on medical cost proposals

Physician and Blue Cross/Blue Shield of Michigan work groups are meeting regularly to hammer out specifics of a much-sought, mutually-agreed-upon service benefit program designed to impact on medical care costs. Study groups representing MDs, osteopaths and the Blues presented working papers on cost awareness at a liaison meeting July 12. The timetable for forging the potential mutual service benefit program has been developed, following the terms of an agreement reached in May by the MSMS House of Delegates and the Blues. The Blues, now that considerable progress has been made, are to institute their prevailing statewide screen in the UCR program for paying all Michigan physicians. "I don't anticipate any problems at all," says Donald K. Crandall, MD, chairman, MSMS Negotiations Committee. "All the Blues board members agree we have met the requirements."

All four principles of the Blues/physician agreement of May must be agreed upon in these work group sessions before any one can be accepted, says Doctor Crandall. They include:

(1) Implementation soon of an effective health care cost control program, (2) an effective service benefit program, (3) reimbursement policies supportive of service benefit and cost containment principles, and (4) equal treatment of all physicians within a reimbursement system consistent with the first three principles.

Doctor Crandall anticipates work of physicians and Blues groups will be completed by January. Full reports then will go to the MSMS House of Delegates for adoption.

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Please remove center section for your state CME records

CAPSULES

IRS ASSOCIATION AUDITS--The IRS has indicated in 1978 it will audit 50 percent of trade associations with income of over $500,000, with emphasis on expenditures for participation or intervention in a political campaign on behalf of any candidate for public office, or in connection with any attempt to influence the general public on legislative matters. These expenses will not be allowable if the attempts are to influence legislation which has no direct business interest to the trade associations' constituents.

* * *

LATER-LIFE ADULT--Do you have a special interest, or expertise, in the care of the late-life adult? If so please write the MSMS Committee for CME Programming, which has established a task force with Charles W. Shipman, MD, Traverse City, as chairman. Or phone Doctor Shipman, 616/947-5550. The task force will search for ways to utilize CME to improve medical care for the elderly.

* * *

TWO MDs SEEK ELECTION--Two Michigan physicians have filed for election to the state legislature. Louis E. (Pat) May, MD, Howell family physician, entered the Republican primary race for a seat in the House of Representatives being vacated by Rep. Thomas Sharpe. Edward C. Pierce, MD, Ann Arbor family physician, filed in the Democratic primary race for nomination for the state Senate seat being vacated by Sen. Gilbert Bursley. Doctor May has five opponents and Doctor Pierce has one opponent, in the primaries.

* * *

MSMS workshop aids jail health car

For the past two years, MSMS has worked actively to improve the health care at seven county jails. Now the project is being expanded to cover 15 jails. Twenty-five Michigan sheriffs, county jail administrators and jail health care specialists attended a workshop July 12 at MSMS headquarters. The workshop was sponsored by MSMS to acquaint the jails people with the process they must follow to have their health care delivery systems accredited by the AMA. Each participant received a large handbook describing all 42 AMA standards for jail health care accreditation. Speakers included Robert E. Medlar, MD, Jackson, director of the Michigan project to improve jail health care delivery. Those attending the workshop came from jails in Alpena, Berrien, Genesee, Ingham, Kalamazoo, Kent, Oakland, Saginaw, St. Clair, Van Buren and Washtenaw counties. Five of Michigan's county jails already have AMA accreditation.

MSMS trio at AMA/Kennedy meeting

As this Medigram was being written, three MSMS representatives were in Washington, DC, meeting with health care leaders from around the country. They were called together by the AMA and Senator Edward M. Kennedy, chairman, Senate Subcommittee on Health and Scientific Research. The three-day meeting was to focus on "Positive Health Strategies." Representing MSMS were Council Chairman Louis R. Zako, MD; chairman, Task Force on Medical Care Costs, Frederick W. VanDuyne, MD; and MSMS Deputy Director Bruce W. Ambrose, head of the MSMS Division on Government Relations. Speakers were to include AMA President Tom E. Nesbitt, MD, Senator Kennedy, and AFL-CIO President George Meany.

MSMS joining health manpower surv

MSMS will be represented on the executive committee of the second Michigan Statewide Health Manpower Survey. The survey will establish the exact number of health professionals, technologists, technicians and assistants in each county, with the goal of developing programs to improve their distribution throughout the state. The survey and its distribution program will be conducted by the Michigan Health Council, funded by the Kellogg Foundation.

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Detach and Use as a File Folder

MSMS, in cooperation with the Michigan Medical Practice Board, developed this Medigram Section to help physicians to understand the new CME rules and to keep their records and evidence.

What do the new CME rules mean for Michigan licensees?	Simpler Medical Practice Board reports each year and more emphasis on audits in enforcing compliance.
Is the possibility of a CME record audit new?	No. The rule requiring a signed statement of CME compliance to accompany a licensure application has warned that it is the licensee's responsibility to maintain evidence.
How important is the keeping of records on CME activities?	Failure to provide such evidence shall be deemed to establish a rebuttal presumption that the licensee made a false and fraudulent statement in applying for a license.
What kind of evidence will be sufficient for the auditors?	Certificates of completion, receipts, cancelled checks--the same type of proofs asked by the Internal Revenue Service.
How long must records be kept?	Four years.
What is the CME year?	January 2-December 31.
Has the amount of required study changed?	Not really, the requirement is more flexible now, being 150 credit hours in the previous three years.
Did the minimum and maximum requirements by category change?	Basically, these have been tripled with the change of the reporting period form 12 to 36 months. The key limits are given with the category record sections on the next pages.
Are there new activities reportable for credit?	Yes, including specialty board recertification, participation in quality hospital care reviews, and medical ethics.
Must the CME report card signature be witnessed.	No.

-licensure cards mailed to physicians will have a CME Requirement Report similar to this form.

CONTINUING MEDICAL EDUCATION REQUIREMENT REPORT

License Number ______________________ Name ______________________

Maximums and minimums are for 3 years duration unless otherwise stated.			Indicate Hours Below			
			1976	1977	1978	Total
CATEGORY 1	Continuing Medical Education activities with accredited sponsorship, including medical ethics (Maximum 150 hours, Minimum 75 hours).					
CATEGORY 2	Continuing Medical Education activities with non-accredited sponsorship (Maximum 36 hours).					
CATEGORY 3	Teaching Medical Physicians or Allied Health Services (Maximum 48 hours).					
CATEGORY 4	Books, papers, publications, exhibits (Maximum 48 hours)					
CATEGORY 4	Non-supervised education: Maximum 36 hours	Self-assessment (Max. 18 hrs.)				
		Self-instruction (Max. 18 hrs.)				
		Quality care or utilization review (Maximum 18 hours)				
CATEGORY 6	Full-time participation in a graduate training program of at least 5 full months (Max. 50 hrs/yr)					
READ AND SIGN OTHER SIDE OF THIS CARD.		Yearly Totals				

Use this folder to record activities and to hold CME programs, notes, receipts

Category 1

Activities with accredited sponsorship; tutorial experience; medical ethics; specialty board certification/recertification

1976 cr.hrs.____

1977 cr.hrs.____

Minimum credit hours (clock hours) in three years: 75; maximum, 150.

ACTIVITY ________________________ Date ______ cr.hrs.____/____

Sponsor or tutor ________________________ Location ______________

ACTIVITY ________________________ Date ______ cr.hrs.____/____

Sponsor or tutor ________________________ Location ______________

ACTIVITY ________________________ Date ______ cr.hrs.____/____

Sponsor or tutor ________________________ Location ______________

ACTIVITY ________________________ Date ______ cr.hrs.____/____

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Sponsor or tutor ________________________ Location ______________

ACTIVITY ________________________ Date ______ cr.hrs.____/____

Sponsor or tutor ________________________ Location ______________

ACTIVITY ________________________ Date ______ cr.hrs.____/____

Sponsor or tutor ________________________ Location ______________

ACTIVITY ________________________ Date ______ cr.hrs.____/____

Sponsor or tutor ________________________ Location ______________

Category 2

Activities with nonaccredited sponsorship 1976 cr.hrs._____

Maximum credit hours (clock hours) in three years: 36. 1977 cr.hrs._____

ACTIVITY ______________________________ Date ______ cr.hrs._____/_____

Sponsor ______________________________ Location ________________

ACTIVITY ______________________________ Date ______ cr.hrs._____/_____

Sponsor ______________________________ Location ________________

ACTIVITY ______________________________ Date ______ cr.hrs._____/_____

Sponsor ______________________________ Location ________________

Category 3

Teaching physicians or allied health services 1976 cr.hrs._____

Maximum credit hours (two per clock hour) in three years: 48. 1977 cr.hrs._____

ACTIVITY ______________________ Audience ______________ cr.hrs._____/_____

Sponsor ______________________ Location ______________ Date ______

ACTIVITY ______________________ Audience ______________ cr.hrs._____/_____

Sponsor ______________________ Location ______________ Date ______

ACTIVITY ______________________ Audience ______________ cr.hrs._____/_____

Sponsor ______________________ Location ______________ Date ______

Category 4

Books, papers, publications, and exhibits 1976 cr.hrs._____

Maximum credit hours (clock hours) in three years: 48. 1977 cr.hrs._____

ACTIVITY ______________________________ Date ______ cr.hrs._____/_____

Event and place
Publication or publisher ______________________________

ACTIVITY ______________________________ Date ______ cr.hrs._____/_____

Event and place
Publication or publisher ______________________________

ACTIVITY ______________________________ Date ______ cr.hrs._____/_____

Event and place
Publication or publisher ______________________________

Category 5

Nonsupervised education

1976 cr.hrs._____

Maximum credit hours (clock hours) in three years: 36.

1977 cr.hrs._____

Self-assessment (Maximum credit hours: 18)
Self-instruction (Maximum credit hours: 18)
Quality care or utilization review (Maximum credit hours: 18)

ACTIVITY ____ cr.hrs._____/_____

ACTIVITY ____ cr.hrs._____/_____

ACTIVITY ____ cr.hrs._____/_____

Category 6

Full-time participation in graduate training program of at least five full months

1976 cr.hrs._____

1977 cr.hrs._____

Maximum credit hours: 50 per year.

PROGRAM SITE ____

Program dates _________

CONTINUING MEDICAL EDUCATION RULES INFORMATION

The Michigan Medical Practice Board will mail complete copies of the revised CME rules to all Michigan licensees. All requests for additional information should be sent to:

Medical Practice Board
905 Southland
P.O. Box 30018
Lansing, Michigan 48909

The board may deny a request for approval of activities for CME credit whenever it appears that the request fails to demonstrate compliance with the legislative intent to further educate licensees on subject related to the practice of medicine.

SUMMARY OF CME CREDIT

	1976	1977	1978
Category 1			
Category 2			
Category 3			
Category 4			
Category 5			
Category 6			
TOTALS			

MSMS public affairs workshop Sept. 20

"Change" will be the theme for the MSMS Public Affairs Workshop Sept. 20 at the Marriott Inn, Ann Arbor, sponsored by the Committee on State Legislation and Regulations. The all-day workshop will explore changes in medical delivery imparted by governmental statute and regulations--and how physicians can influence and shape change. In the morning session AMA and MSMS leaders will review changes in 1978 in the state and nation; health planners, third party payers and patients will look ahead in the afternoon session. At noon Rep. William Ryan, speaker-emeritus of the Michigan House of Representatives, will discuss the philosophies of change. Oliver D. Grin, MD, Grand Rapids, conference chairman, announces reservations now are being taken at MSMS headquarters. Registration is $15, including lunch. For information, contact Bruce Ambrose, MSMS headquarters.

Council moving on House resolutions

Policies established by the delegates to the 1978 MSMS House of Delegates meeting in May are being put into action. Ten important resolutions have been assigned to The MSMS Council to implement. MSMS Chairman Louis R. Zako, MD, reviewed them at the midsummer meeting of The Council. They include Resolution 2, for medical society input on medical record confidentiality; Resolution 7, for continuous MSMS evaluation of CME quality, relevance and costs; Resolution 8, for MSMS to closely monitor HMO development; Resolution 9, for MSMS to study feasibility of a new independent mutual hospitalization insurance company; Resolution 11, for uniform action by hospitals and physicians in child abuse cases; Resolution 12, to approve MSMS Council actions of the previous year; Resolution 27, for MSMS to help develop an arbitration training program; Resolution 43, for MSMS to communicate to the federal government its concern over the high cost of developing PSROs; Resolution 45, for MSMS to help do whatever is necessary to aid the Grigg-Wendling suit; Resolution 55, for MSMS to investigate formation of a physician union or guild; Resolution 58, for MSMS to study establishment of a commission on medical care costs; Resolution 59, for MSMS to establish a task force to promote medical practice in rural communities; Resolution 64, for MSMS to be fully informed of impending Medical Practice Board rules and regulations, and for MSMS to assess the impact of the new rules and regulations on amphetamines; and Resolution 56, for an MSMS ad hoc committee to establish policy concerning physicians assistants.

CAPSULES/continued

CONGRATS TO MSMS--The following letter was received recently at MSMS headquarters from James H. Sammons, MD, executive vice president, American Medical Association. MSMS Director Warren F. Tryloff wished to share it with all MSMS members: "The stunning defeat administered to President Carter's hospital cost control legislation by the House Commerce Committee is a tribute to the joint AMA-hospital association's voluntary effort program, other cost awareness programs by physicians and hospitals, our Washington office and the splendid cooperation of state medical societies. Congratulations to you and your society for the important role you played in this great victory."

* * *

AMA-ERF CHECKS--MSMS and the AMA have presented checks totaling $24,228 from AMA-ERF to the three Michigan medical schools as unrestricted grants. This year, the AMA-ERF is distributing a total of $1,150,000 to the medical schools of the nation. In Michigan, the checks amount to $12,789 to the U-M; $7,595 to WSU and $3,844 to MSU. The MSMS Auxiliary traditionally is active in this fund-raising project, part of the AMA-ERF loan guarantee program which last year helped 5,000 medical students and house officers borrow more than $7.3 million.

* * *

CREDIT CARD PAYMENTS--Ingham County physicians are participating in a special pilot project on the use of credit cards in their offices. The project is advocated by MSMS and by the Ingham County Medical Society. Under the project, patients may pay medical bills by credit card, with the physician charged three percent for use of the system.

DATES CHANGED--The 1979 Michigan Conference on Maternal and Perinatal Health has been rescheduled for Feb. 28-March 1 at the Dearborn Hyatt Regency. The original dates conflict with a national ob-gyn meeting. The conference cochairmen are Bruce A. Work, Jr., MD, Ann Arbor and John Hallitt, MD, Flint.

* * *

DOCTOR McMURRAY APPOINTED--Richard L. McMurray, MD, Flint, has been named by MSMS President Heideman to fill the vacancy on the MSMS Judicial Commission created by the election of Richard L. Rapport, MD, Flint, to The MSMS Council. Doctor McMurray represents the 4th Judicial Commission District.

* * *

CMA VICTORY--The California Medical Association was successful in defeating a bill there that would have given the California Health Facilities Commission authority to review and approve the annual budgets of hospitals.

MDs can earn up to 18 hours at MSMS Scientific Meeting

"While your thinking is focused on CME credits as you read this issue of Medigram, remember you can earn up to 18 hours of Category I credit at the MSMS Annual Scientific Meeting Nov. 7-8-9," urges Carl F. Hammerstrom, MD, chairman of the MSMS CME Programming Committee.

"Many physicians now are planning their work schedules around opportunities to earn the CME credits required by Michigan law. I would urge all MSMS members needing hours to plan now to attend the Annual Scientific Meeting. Nowhere will you find higher quality courses at more reasonable rates ($4 per credit hour for MSMS members; $8 per credit hour for non-members)," says Doctor Hammerstrom.

The Annual Scientific Meeting Program Planning Committee has made a special effort to develop courses to provide practical, relevant information to practicing physicians. A total of 57 courses is scheduled during the three-day meeting.

Chiropractic expansion in court

A declaratory ruling by the chiropractic practice board to expand the scope of chiropractic has been enjoined by Ingham Circuit Court Judge Jack Warren. A public hearing is set for Sept. 12. Both the attorney general and the Chiropractic Council sought the injunction to prevent application of the board's ruling pending court action. The chiropractic board had adopted by a 5-2 vote the ruling that would permit chiropractors to perform blood tests, use non-narcotic drugs, perform acupuncture, pap smears and other medical procedures. The vote was split between the chiropractic "progressives" and "straights" on the board. The "straights" are members of the Chiropractic Council. Action seeking the injunction held that the ruling goes far beyond legislative intent and judicial rulings of the past.

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BREAKING NEWS FOR MICHIGAN DOCTORS
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Physicians, Blues studying cost containment proposals

Physician and Blue Cross/Blue Shield of Michigan work groups will meet for the fourth time Aug. 22 at BCBSM headquarters, continuing their efforts to prepare a service benefit program which also will help contain medical care costs, according to Donald K. Crandall, MD. The Blues representatives announced their prevailing statewide screen in the UCR program went into effect for all Michigan physicians Aug. 1, as anticipated.

At an Aug. 1 meeting, the Blues distributed copies of their proposed cost containment proposals, which now are being studied in detail by the physician representatives. MSMS and the Michigan Association of Osteopathic Physicians and Surgeons earlier prepared papers outlining their ideas for containing costs. At the Aug. 22 meeting, the position papers by Blues and physicians will be discussed, and MSMS and MAOPS will submit alternative proposals for accomplishing cost containment.

MSMS steering group at work on health planning

Assistance to physicians who serve on health systems agencies or on committees and task forces of HSAs was programmed Aug. 7 by the MSMS Steering Group on Health Planning, Chairman Kenneth Ray, MD, Trenton, announced. Called for by a resolution of the House of Delegates, the steering group moved to carry out the promise of the House resolution to "intensify (MSMS) concern with health planning" and "assist in all possible ways the component societies, their executives and member physicians who serve on Health Systems Agencies." The steering group expressed satisfaction with coverage of the Statewide Health Coordinating Council by MSMS, also called for in the resolution, but cited the primary need for support of physician viewpoints at the HSA level. MSMS staff will begin immediately to meet personally with doctors in the planning process as well as component society and HSA staffs.

UP CME MEETING

Upper Peninsula physicians and those from downstate interested in a mini-vacation combined with an opportunity to earn nine hours of Category I CME credit should plan on a Sept. 23-24 weekend in Marquette. Co-sponsored by MSMS and the Michigan Academy of Family Physicians, a regional CME project that weekend will offer courses in allergy, dermatology, pharmacology, neurology, "biliary tract diseases" and "electrolytes and blood gases." Interested physicians should write or call MSMS for further details. Meetings will be held on the campus of Northern Michigan University. Motel reservations can be made at the Holiday Inn or any of several other motels in Marquette.

CAPSULES

REATMENT OF MINORS--Minors of ny age who are mature enough o understand the nature of nd consequences of requested reatment, may give valid, inormed consent on their own ithout parental consent, for wide variety of medical care ncluding contraception, pregancy-related care, abortion, enereal disease and substance buse. In addition, there are o existing Michigan laws or tatutes which make the giving f such care by Michigan phyicians to mature minors an llegal or illicit act. So ays Charles J. Berger, MD, edical chief, Div. of Materal and Infant Health, Michian Dept. of Public Health, n response to an article pubished in the July issue of ichigan Medicine in which hese positions were incorrecty stated. A more detailed iscussion of Michigan laws on eatment of minors will appear n the September "letters" olumn of Michigan Medicine.

CAPSULES/continued

FILING CME RECORDS--"Did you start recording your CME activities on the handy CME records folder that was part of the July 31 issue of Medigram?" That question is asked by James H. Tisdel, MD, vice-chairman of The MSMS Council and chairman of the MSMS Committee on Publications. "Considerable staff time and effort was spent to design that folder for doctors to actually use in their office files," Doctor Tisdel points out. The folder carries copy to answer some of the questions physicians have about the new regulations that govern the reporting of CME credits to the state for relicensure. Copies may be obtained by writing the Div. of Public Service, Communications and Physician Education, MSMS headquarters.

* * *

ANNUAL SCIENTIFIC MEETING--The preliminary program and registration form for the 1978 MSMS Annual Scientific Meeting will appear in the first September issue of Medigram. Watch for it. That issue will include course descriptions, lists of faculty members and other details to help physicians register for the 58 half-day Category I CME courses that will be offered Nov. 7-8-9 at the Detroit Plaza in the Ren Center. Program planners are very enthusiastic about the excellent Michigan and out-of-state instructors who have been obtained.

US Senate votes CON for doctors' private offices

By a narrow three-vote margin, the U.S. Senate has approved a provision in the federal health planning bill (S 2410) mandating certificate of need (CON) review for physician office equipment purchases of more than $150,000. The AMA and the National Conference of State Legislatures stood alone against a combination of organized labor, HMO and HSA forces, the American Hospital Association and some governors in opposing certificate of need for private physicians' offices. The bill now goes to conference with the U.S. House of Representatives, which earlier had voted to delete the provision. AMA reported the strong, if losing, showing in the Senate gives physicians "an excellent chance yet of coming out of conference with a much less drastic and unreasonable compromise." One hundred Michigan physicians joined in the AMA effort to thwart the provision, through contacts with Senators Griffin and Riegle. Personal visitations with both were conducted by Louis R. Zako, MD, MSMS Council chairman, and Frederick W. VanDuyne, MD, chairman, MSMS Task Force on Medical Care Costs.

Medicaid appropriations veto draws MSMS responses

MSMS has written the Department of Social Services supporting the governor's recent veto of sections of the Medicaid Appropriations bill. MSMS, however, reminded the DSS that funds for physicians' services must be reinstated prior to the Oct. 1 deadline. In a last-minute move, the governor vetoed those line items in the DSS appropriations which discriminate against abortion services for Medicaid patients. "The action is entirely consistent with the policy of the MSMS House of Delegates action in May to support the practice of state funding of abortions for Medicaid patients," wrote David Siegel, MD, chairman, MSMS Medicaid Liaison Committee, to the DSS. "However...we realize the legislative discussion may be hampered by heated debate which could cloud the real issue of appropriations to reimburse physicians under Medicaid."

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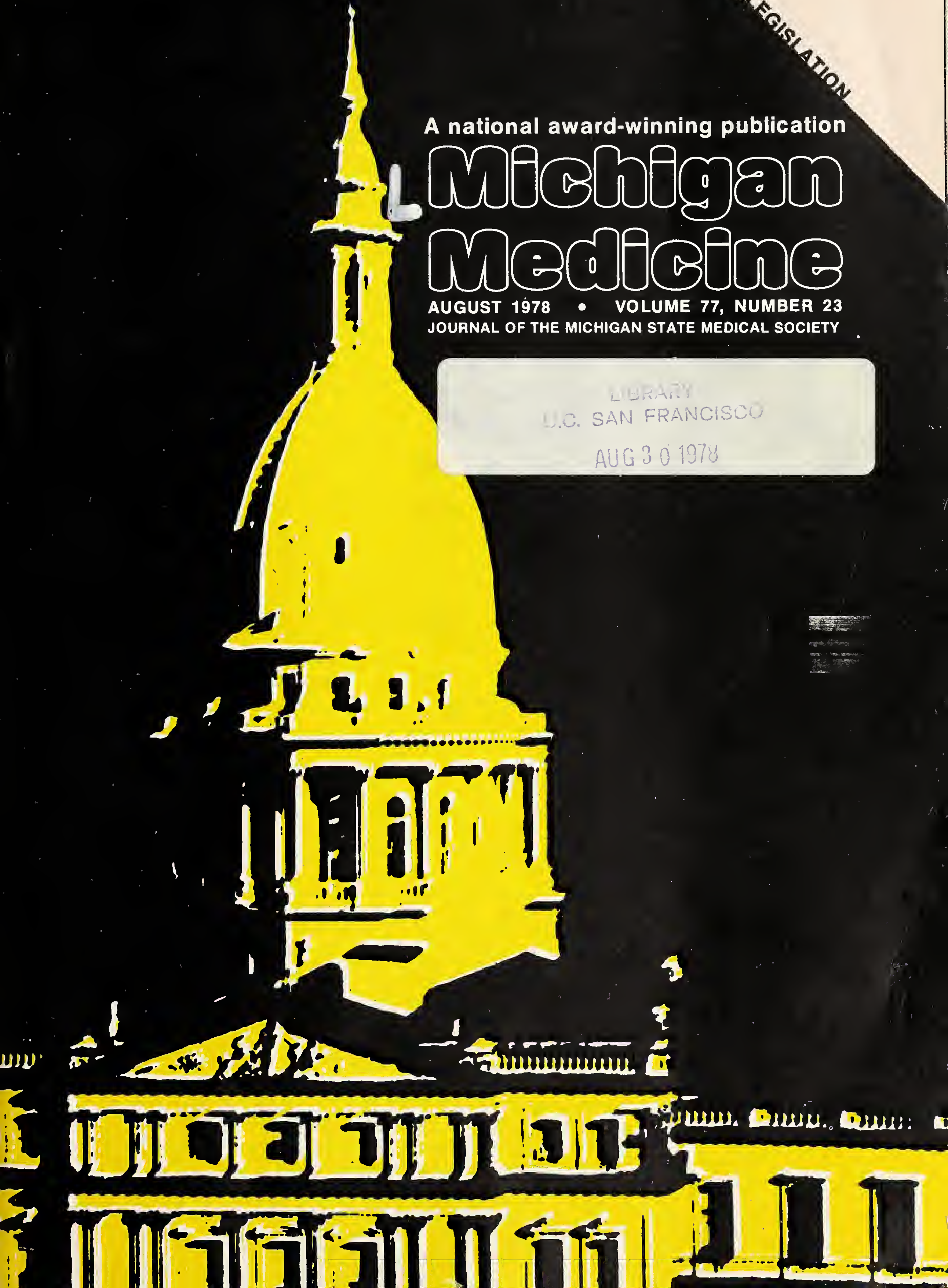

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

ALLEN STROSS

In the special section this month, *Michigan Medicine* reviews legislation of the past 18 months, and looks into the future through the eyes of W. E. Maldonado, MD, chairman, MSMS Committee on State Legislation and Regulations.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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MSMS legislative chairman reviews, looks forward, in Capitol activity

(The following report reviewing MSMS' legislation program now before the current Legislature and its implications for the future was delivered July 8 at the Mid-summer meeting of The Council.)

By W. E. Maldonado, MD
Lansing

I am pleased to share this update on the activities of the MSMS Committee on State Legislation and Regulation.

Every member of the committee shares the MSMS view that organized medicine's dealings with government — federal, state and local — must be of the highest station in the medical society's order of priorities. Thus the committee members serve willingly, not only at regular meetings, but also on numerous subcommittees and task forces.

The committee's charge is such that excellent staff is vital. I feel comfortable in commending to The Council the staff support this committee has and is receiving.

I hope to review for you some of the functioning of the committee, some of our achievements — our disappointments — our hopes — and some of our concerns.

The period of time covered by this report begins Jan. 1977, when the current Legislature convened, to July 1, when it adjourned its 1978 Spring session. During this period there have been two committee chairmen, and credits, where credits are due, are owed to Thomas R. Berglund, MD, Kalamazoo. Tom chaired the committee for five years, until last summer when he was elected a member of The Council. It was then I was honored to be named chairman.

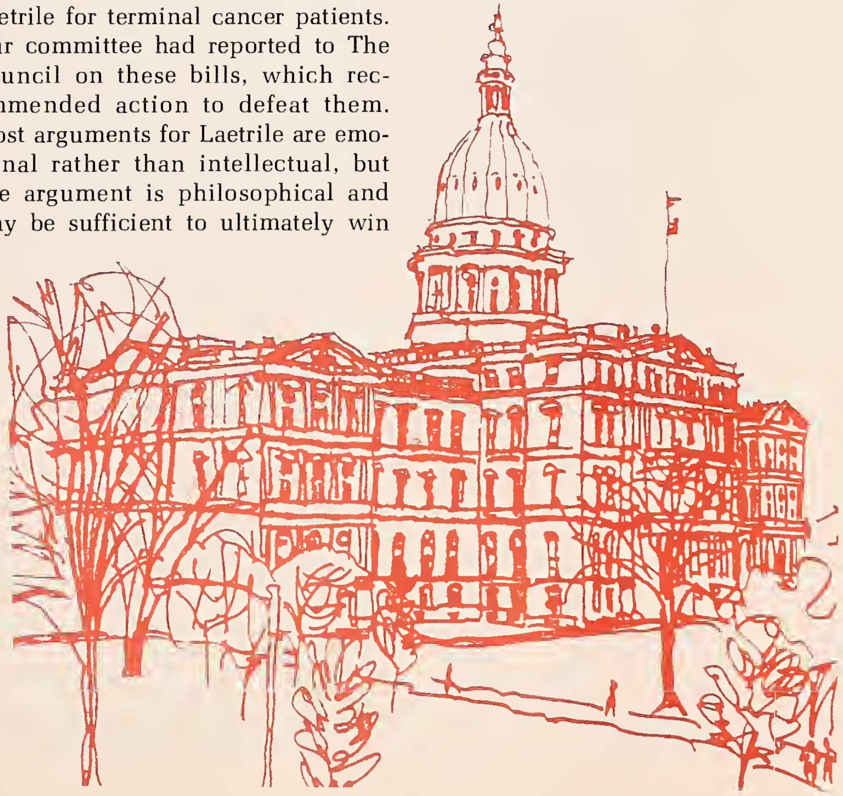
The committee has focused on 54 bills in the past 18 months. The committee also contributed to legislation at the conceptual stage before it was written into legislative proposals. For example, the Insurance Commissioner presented to us last autumn his thoughts on restructuring the board of directors of Blue Cross-Blue Shield, and MSMS spent considerable time evaluating his ideas.

I do want to call your attention to a few bills, to illustrate that as much of our work lies in resisting legislation as in supporting legislation. Some success is invisible, as some legislation does not come to fruition, due in part at least to MSMS endeavors.

Note, for instance, House Bills 4903, 4913, 4914, 4817 and Senate Bill 576. These all are bills designed to legalize, in one fashion or another, Laetrile for terminal cancer patients. Our committee had reported to The Council on these bills, which recommended action to defeat them. Most arguments for Laetrile are emotional rather than intellectual, but one argument is philosophical and may be sufficient to ultimately win the Laetrile debate. That argument is that terminal patients ought to be privy to alternative methods of treatment. This argument likens Laetrile to radiation or chemotherapy. The people doing our lobbying were successful in convincing the committee to establish a study subcommittee, which will work this summer to determine what has happened in those states which have already authorized legal manufacture and distribution of Laetrile, and to further ponder the argument of a patient's right to his own preferred treatment methodology.

Another idea which never developed into final legislation, due mostly to MSMS efforts, was SB 347, which could have required massive research into past X-ray records and notification of patients who may have been exposed to radiation dangers during their childhood. This

(Continued on page 421)



Doctor Maldonado is chairman of the MSMS Committee on State Legislation and Regulations.

457-page PHSRP bill finally passed five years after recodification begun

The new Public Health Code has finally passed the Legislature and gone to the Governor for his signature. The MSMS Committee on State Legislation and Regulation followed this vast piece of legislation closely throughout its development and its enactment. The recodification goes back five years to the first statement by Maurice Reizen, MD, director, at the centennial of the Michigan Department of Public Health that a recodification of Michigan's public health laws was necessary.

An MSMS task force of physicians to monitor and advise the Public Health Statutes Revision Project (PHSRP) was chaired by James Read, MD, Pontiac. For many months this task force met monthly or more often to help mold and shape the original PHSRP document. Whatever the outcome, the directions that PHSRP began to take in its early stages were successfully changed and/or thwarted by this task force.

Broad changes

The bill is so large (457 pages) that a full description is impractical in this space. There are some broad points that ought to be made, and one or two specific things. Much of the bill deals with bringing up to date the structure of the department of Public Health and how it relates to the county health departments; with how the department may collect and store research information and the confidentiality of that data; with governance of fluoride programs and other long-standing public health programs whose enabling legislation needed modernizing.

Other large parts of the bill merely weave into the recodification fabric recently-enacted health legislation such as emergency medical services, drug abuse and controlled substances, and health maintenance organizations.

The major changes of interest to physicians and other practitioners lie in three categories — licensing, certificate of need and hospital bed reduction. The principles of the Medical Practice Act of 1973 are retained, and many of them incorporated in other professions' licensure. The Medical Practice Board will consist of 10 physicians, as now, three public members, as now, and one physician assistant has been added. Other licensing boards, most of which are smaller than the Medical Practice Board and license fewer persons, will have a majority of professional members and two public members, and where indicated one auxiliary professional. The process of licensing physicians and reregistration remains constant.

The certificate of need section has been very controversial. MSMS staff in the Capitol has been constantly challenged by persons and groups seeking to extend certificate of need into physicians' private offices, or seeking special considerations and exemptions for themselves. The last and best example was a move by osteopathy to have a separate certificate of need requirement for osteopathic facilities. This would have had the effect of giving independent consideration to osteopathic facilities rather than in combination with general medical facilities. The amendment was defeated by only three votes.

MDs' offices exempt

As finally adopted, the PHSRP certificate of need section requires certificate of need for all health facilities except private practitioners' offices. There is a CON requirement for "tertiary health care facilities" which are defined as a "facility that provides services for patients referred by a physician for diagnostic tests and that reports findings to the referring physician." This effectively means outpatient radiology and outpatient pathology. Thus, the certificate of need line appears to fall between the physician with direct patient relationships and the consulting diagnostician.

Related to all this is the federal health planning legislation now being amended in Washington, where serious consideration is being given to requiring certificates of need for all medical equipment costing more than $150,000 regardless of location. If adopted, the state certificate of need requirements would have to conform to the federal requirements.

The hospital bed management proposal was originally a separate bill, but was incorporated into the Public Health Code for consistency. The section requires that health systems agencies plan for the reduction of beds identified as excessive over a five year period.

The Public Health Code is so large and so complex that MSMS will obtain an impartial review and analysis of the entire bill, for use by all our members.

Additionally, MSMS will closely follow the implementation of the Code, including promulgation of rules and regulations. Of particular concern will be the process whereby the state implements the provision guaranteeing "basic health services" to all citizens of the state. The Department of Public Health has designated Stuart M. Paterson responsible for implementing the Public Health Code. The MSMS Committee on State Legislation and Regulation will consider whether another task force is indicated to assure MSMS input in the process.

legislation would have been extremely expensive for a minimum amount of benefits. Voluntary notification of most persons exposed to this kind of radiation served to avoid legislative action.

MSMS accomplishments

There have been accomplishments in passing important legislation.

Recall in May of 1977 when the Brown-McNeely state malpractice Insurance fund faced extinction, which could have re-created the intense market shortage for malpractice insurance that existed in and prior to 1975.

Several committees of MSMS worked with the Insurance Commissioner to write a bill which would extend the life of the Brown-McNeely fund and at the same time establish a stabilization fund within Brown-McNeely to reduce the risk of a general assessment against all Michigan doctors.

This bill was introduced and legislated within a 30-day period, and has provided a two-year time period in which physicians insured by Brown-McNeely can be absorbed by our own insurance company (MPMLC) or other commercial markets.

Looking ahead, a year has passed since this legislation: Unless we resolve the market-place for Brown-McNeely insureds, we may have to go through this exercise again.

Further examples of legislative enactment of MSMS-preferred bills are House Bill 4936, which requires continuing medical education credits for licensed physicians in three-year 150-hour blocks rather than in one-year 50-hour blocks; House Bill 4425, which finally, after a 10-year debate, permits teaching of human sexuality in public schools, House Bill 4340 and others. You may recall that HB 4340 removed the requirement that two doctor members of the Medical Practice Board had to serve at every disciplinary hearing, and *that* requirement presented a logistical impossibility. MSMS developed a list of physicians who are willing to serve as monitors at board hearings, and that action persuaded the Legislature to adopt HB 4340.

If we are to recite our successes of passage or non-passage of legislation, then we ought also to recite our disappointments.

MSMS was the sole organization objecting to the "tertiary health care facility" in the Certificate of Need section of the new health code. We lost our argument.

Since enactment of the definition of malpractice statute last fall, MSMS has had no success in obtaining legislative interest in further malpractice legislation.

We have caused to be introduced Senate Bill 1599, which would qualify expert witnesses in malpractice litigation, but we have, to this point, been unable to attract attention to the bill. We expect it to be re-introduced next year.

Neither have we been successful in promoting Senate Bill 477, which would earmark funds for the Medical Practice Board based on re-registration fees. And, as we know too well, we have been totally unsuccessful in obtaining significant tax relief from the Single Business Tax.

* * *

I think it is necessary to appreciate the political environment in which the committee and staff works. As election follows election, and new legislators and their staff support come onto the Lansing scene, the dominant motives of the Legislature change. Most current members of the Legislature believe that new legislation, or changes in current statute, must be perceived in the context of what is best for consumer (patient) rights or protection.

I am sincerely impressed with the intellect, the idealism and the capacity to work of the current generation of legislators. On the other hand, I believe physicians must deal with the Legislature from the perspectives of cost consciousness, access to medical care, as well as our usual stand for quality care. A prime example of working together in this context is the "Medicare parity" section of the Medicaid appropriations bill. This increase in Medicaid reimbursement came about because the Medicaid Liaison Committee convinced the legislators it would assure access to medical services for Medicaid clientele.

In meeting this challenge of working with all legislators, we are greatly in debt to two programs:

Component societies which hold regular meetings in their home towns with their local legislators go far in gaining access by MSMS to their legislators in Lansing. And the MDPAC board has been uncanny in supporting for election members of the Legislature from every spectrum of political conviction, who also recognize and tend to legislate in the light of medical imperatives.

* * *

If there is one single issue that the Committee on Legislation and Regulation has struggled with in the last several years, it is the new Public Health Code. That legislation finally passed the Legislature and went to Governor Milliken for his signature in the last days of June. The Committee on State Legislation followed this vast piece of legislation consisting of 457 pages throughout its development and its enactment. The minutes of The Council are replete with reference to PHSRP in the last four years. (A review of PHSRP accompanies this report.)

* * *

Doctor Maldonado

Of equal importance with PHSRP is the annual appropriations lobbying in behalf of the Medicaid program. Our committee works well with the MSMS Medicaid Liaison Committee, chaired by David Siegel, MD. The Committee on State Legislation and Regulation accepts the goals drafted annually by the Medicaid Liaison Committee for the Social Services budget. Then the two committees jointly work with legislators to achieve these goals.

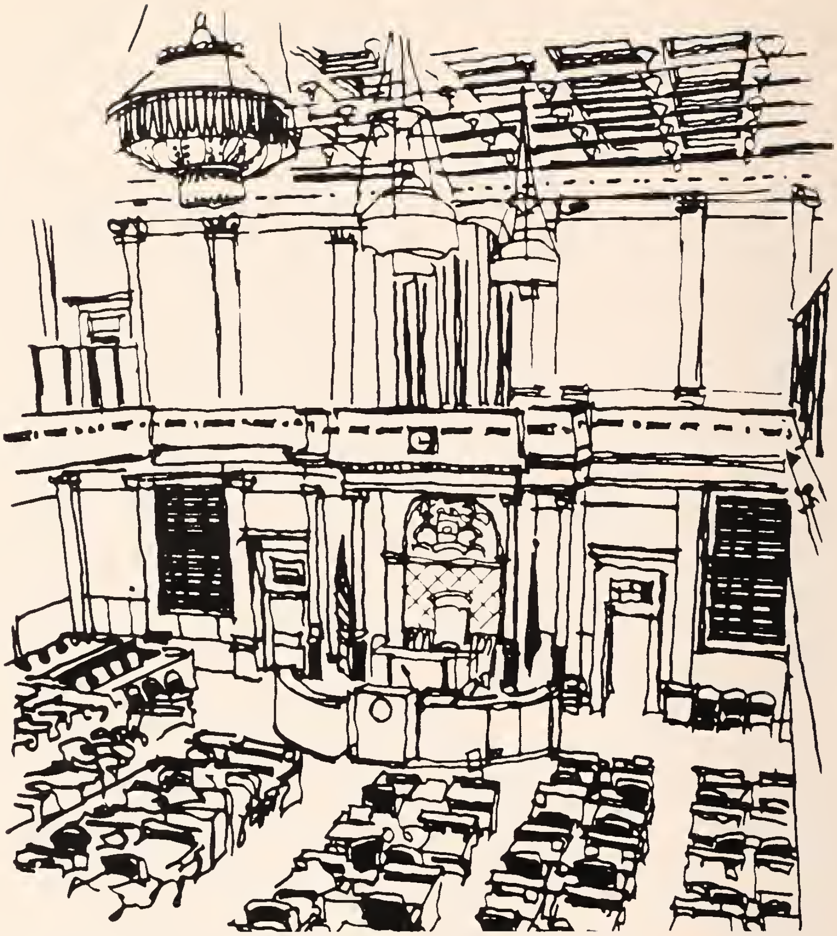
The Committee on State Legislation and Regulations functions strictly as a support group to the Medicaid Liaison Committee in this annual legislative endeavor. Credit for the freshness of the Medicare parity idea, which has drawn national attention, accrues to the Medicaid Liaison Committee — and we are only happy to follow its lead.

* * *

Because the committee is charged with regulations as well as legislation, some degree of committee time is spent on rules and regulations proposed and implemented by state government. Other society committees share this task with us — the Medical Practice Board Liaison Committee has assumed coverage of those rules pertaining to licensure, the Medicaid Liaison Committee watches those governing Medicaid.

A major concern recently of the committee over regulations has been monitoring the growth and development of health planning. Dan Mazzuchi, MD, of Marquette has served as an unofficial sub-chairman of this project, and has reported regularly to the committee on activities of the Statewide Health Coordinating Council. I am pleased, however, over the actions of the House of Delegates in directing establishment of a full committee on health planning. I think this committee's work will become of equal importance to doctors as that of the Medicaid committee and the legislative facets of the Committee on Legislation and Regulation.

Other regulatory functions of the committee include rules promulgated by the Department of Public Health, and rules issued by the Department of Education as they influence health services for children.



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Finally, to make this report complete, mention must be made of some of those organizations with which we often work together. Of course, we work closely and well with the Michigan Hospital Association, assisting one another when we can. We have a good working relationship with the United Auto Workers and AFL-CIO lobbying forces. On occasion we coordinate with the osteopathic physicians and with other health professions' organizations when our goals coincide. On malpractice issues and often on social-medical issues we tend to find the Michigan Catholic Conference a friend. Certainly, the help we receive from the Department of Public Health and other executive agencies is a paramount factor in our work.

* * *

As we look ahead, we sense portents that the encroachment upon the traditional delivery of medical care will accelerate. The ambitions of some people to proscribe fee-for-service will gather impetus. The costs of government medicine, like private medicine, cause great concern in the Capitol Building. The errors of well-intentioned people who want to regulate to perfection will create additional problems. Advances in technology always bring with them political problems.

Toward a greater understanding of what lies ahead, The Council has authorized the committee to hold a statewide conference next fall on public affairs. The committee will dedicate this summer to preparing for that event.

Doctor Heideman leading MSMS efforts to coordinate physician input to auto contracts

MSMS leaders, headed by MSMS President Louis E. Heideman, MD, Detroit, are awaiting final reports from Michigan's medical specialties on items physicians would like to see included in the UAW negotiations next spring with the Big Three automobile manufacturers.

Blue Cross/Blue Shield of Michigan in late spring invited MSMS to be a focal point for physicians' views and recommendations on benefits for auto workers. This kind of contribution to the auto workers' negotiations long has been desired by MSMS members.

Letters were sent by Doctor Heideman to all specialty societies early in June before further instructions were sent to the specialties by the Blues. The Michigan Council of Medical Specialties is coordinating the efforts.

Specialty societies are asked to have their final recommendations to MSMS headquarters by Sept. 1, with Nov. 1 the target for MSMS to complete its report to the Blues.

Interested MSMS members also have been asked to offer their comments in writing.

The final MSMS report will consolidate the specialty societies' reports, consolidate individual physicians' comments, provide general MSMS observations and recommendations and include a copy of every report from specialty societies and individual members.

"MSMS leaders are very pleased the Blues are inviting MSMS to serve as a focal point to obtain views of physicians and physician organizations," observes Doctor Heideman. "For many years, physicians have asked for more involvement in the negotiations conducted by the auto industry and the UAW.

"We now have that opportunity. I know we will do a thorough, conscientious job."

MSMS committees studying relevance of CME courses

Both the MSMS committees on CME accreditation and on CME programs have started to study Resolution 78A-7 adopted by the MSMS House of Delegates. The resolution called for the MSMS committees "to conduct a continuous evaluation of the CME quality, relevance and cost of CME courses." The CME Programming Committee discussed the matter June 8 with Chairman Carl F. Hammerstrom, MD, Marquette, presiding, and the Accrediting Committee, with Richard W. Pomeroy, MD, Lansing, chairman, began its evaluation at its meeting June 14. There will be coordination of efforts between the two active MSMS committees.

Public affairs conference planned for fall

A statewide Public Affairs Conference will be sponsored for MSMS members in the fall by the MSMS Committee on State Legislation and Regulations. The theme will be "rapid pace of change" and the program will try to help physicians understand the changes in government medicine and government programs which affect medicine. The project has been in planning for some time, with The MSMS Council giving its approval back in May. Further details will appear in future issues.

Coming Up Soon for MSMS Members

MSMS Annual Scientific Meeting, Nov. 7-8-9

Coming soon in Michigan Medicine will be some of the details for the 1978 MSMS Annual Scientific Meeting. Physicians will again be able to combine a mini-vacation with the spouse with the chance to earn Category I CME credits.

(See further details page 430).

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MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

For: Frank J. Kelley, Michigan Attorney General.

"Some chiropractors in our town are advertising as 'chiropractic internists.' That's misleading. How can we stop them?"

Mr. Kelley

As you may know, during the past three years I have filed a number of lawsuits and obtained injunctions against chiropractors who are alleged to have engaged illegally in the practice of medicine. The activities in question have included forms of advertising, as well as various acts of diagnosis and treatment. More specifically, in a complaint filed against a chiropractor on Jan. 20, 1976, I quoted his advertising and alleged that his use of the designation: " 'Chiropractic Internist' constitutes a holding out that he offers healing arts services to patients which are beyond the scope of chiropractic and which constitute the practice of medicine in violation of the Medical Practice Act." Trial of that lawsuit has not yet been completed.

Subject to final resolution of this issue by the court, you may notify me of any chiropractors holding themselves out to the public as "chiropractic internists" and, if the court agrees with my position, I will take action to stop that practice.

For: John B. Bryan, MD, Chairman
MSMS Committee on Claims Form and Michigan Uniform Code

"What codes must I use on the various forms for filing claims with patients' insurance carriers?"

Doctor Bryan

The MSMS Committee on Claims Form and Michigan Uniform Code advises Michigan physicians to use the Michigan version, National Association of Blue Shield Plans code for all procedural claims forms. This code was worked out by the MSMS Committee on Negotiations in cooperation with the Michigan Medicaid system and Blue Cross/Blue Shield of Michigan. It is accepted by all third party carriers in the state by mutual agreement and its use will facilitate processing of forms and reduce the error rate. Other procedural codes have to be converted to the Michigan NABSP code system in processing.

For diagnostic codes, physicians are advised a single new system will go into effect in January, 1979. The new structure will be a combined and revised version of the present ICDA and H-ICDA codes. Its major change will be the addition of a fifth digit to further define the present four-digit structure.

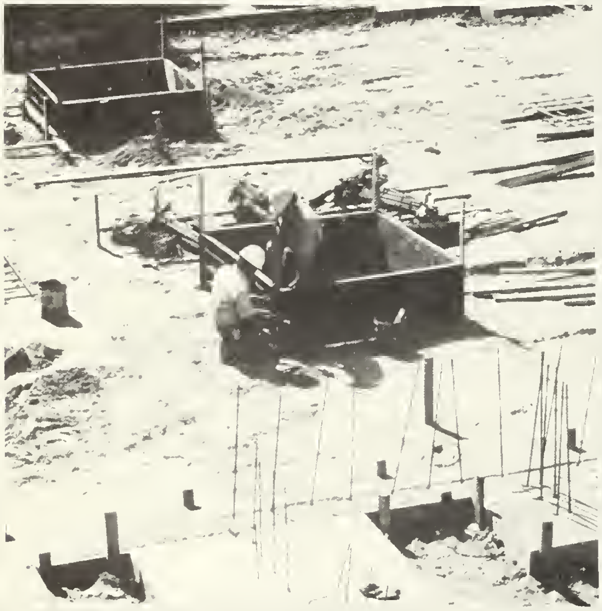
For: Tom Jones, Michigan Insurance Commissioner

"Are physicians required to fill out medical report forms related to no-fault insurance claims, and can they charge for them?"

Yes, they are, if the insurance company deems it necessary, and physicians may charge for filling out the claims.

Mr. Jones

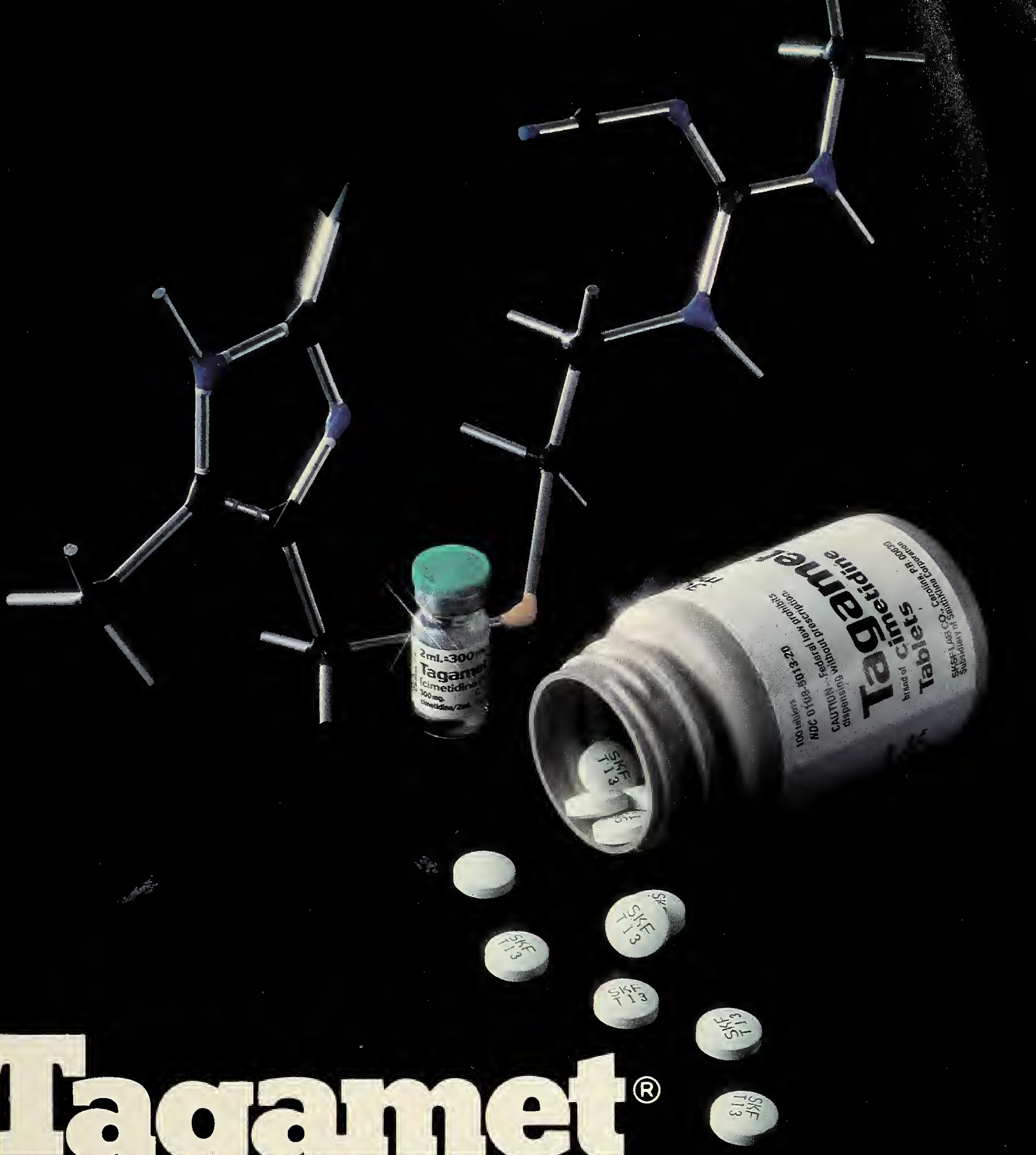
The groundbreaking for the addition to MSMS headquarters in East Lansing took place in June, with MSMS immediate past president Vernon V. Bass, MD, left, and MSMS President Louis E. Heideman, MD doing the honors with the shovel.



The work is moving rapidly as the footings and supports for the new building take shape. Occupancy is expected in January, 1979. The new space will allow for important future expansion of MSMS services to members. Space also will be leased to one or more firms in the medical field.

Progress report on new addition to MSMS headquarters

Construction of the new building required the removal of many beautiful pines from the grounds west of the present MSMS headquarters, with the above view resulting from inside the present building.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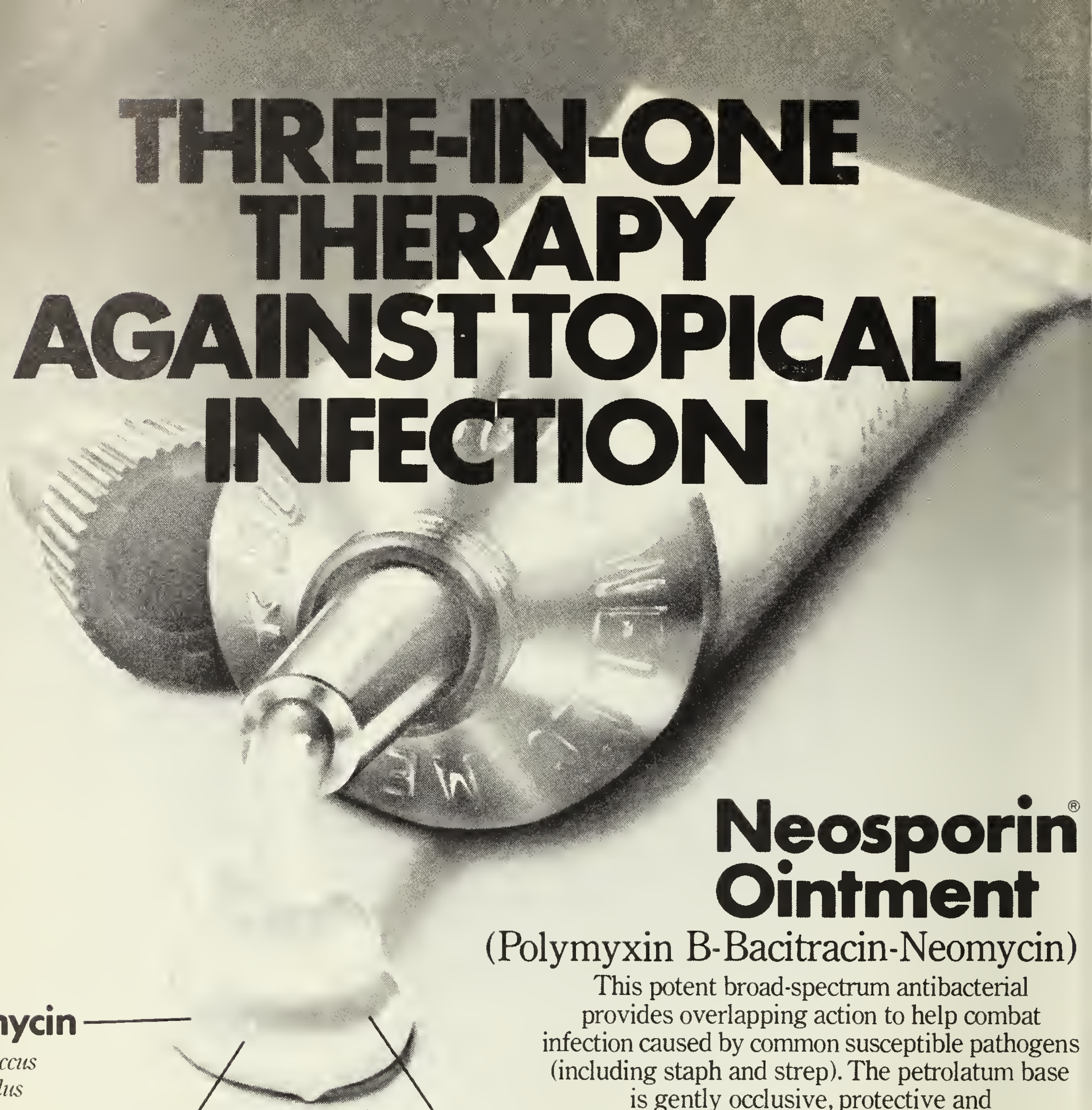

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Seeing 'physicians in action' great benefit of AMSA-MECO

By Elmer White
***Special to* Michigan Medicine**

Everyone seems happy with this year's AMSA-MECO program. This includes 33 medical students and 19 Michigan hospitals.

Random calls found enthusiasm for the program among the students and enthusiasm for the students among hospital administrators.

The plan, now in its eighth year, is worked out between the three Michigan chapters of the American Medical Student Association and MSMS. Among its goals are the introduction of first or second year students to delivery of health care at community levels, helping students evaluate their career goals, and developing an awareness among practicing physicians of the changing nature of health care delivery involving personnel organization and payment systems.

Students came into the program from varying backgrounds, but many had already accumulated experience as volunteers in Red Cross programs, nurse or orderly work, aides at hospitals or at free clinics or with the mentally retarded. One had worked with a British hospital.

Great expectations

Most expressed specific hopes that the program would help them learn things they had not yet learned in medical school. One said he hoped "to learn clinical skills that are so disappointingly absent during preclinical years."

Daniel Hull, at Mercy Hospital in Grayling, is interested in the humanistic aspects of disease and how things work in community medicine.

Michael J. Lucas, Kelsey Memorial Hospital in Lakewood, wants to see how health care is delivered in small towns, especially how geriatric needs are met.

After three weeks' experience at McKenzie Memorial Hospital in Sandusky, David B. Bresnahan says the program is a fine thing. He is learning something about all aspects of the hospital, is able "to get his hands into his work," enjoys talking with patients and subsequent discussion of cases with doctors. "It's like having a tutor," he says.

Annette Zipple spent her first week at Providence Hospital in Detroit in obstetrics where she was pleased to scrub and help with deliveries. She is looking forward to her coming weeks in surgery and medicine.

Staff members pleased

Paul E. McNamara, administrator at Clinton Memorial Hospital in St. Johns, is an enthusiastic supporter of the AMSA-MECO program. His hospital has no other intern or resident contact, so this project provides stimulation among hospital staff members who are pleased to work with young medical students. Townspeople are equally pleased to know a young person is interested in their community. Although it is a 40-hour per week program, the students work long periods because they are so interested. "We make a real effort to get them around the community," says Mr. McNamara. "We even arrange trips for them to dentists' offices, pharmacies, health departments and the Rotary meetings."

It is quickly apparent that most staff people take keen interest in students. Barbara Hansen, executive medical staff secretary for the plan at Hackley and Mercy hospitals in Muskegon, speaks warmly of students she has known over the past five or six years.

"We've never had an unhappy relationship here," she says, and she remembers many pleasant experiences and relationships. One student, now Daniel Crabtree, MD, decided to establish his practice in Muskegon after his training period.

Hilda Sundberg, medical staff secretary for the students at Community Hospital and Leila Y. Post Montgomery Hospital in Battle Creek, is proud of a heavy file of letters from students who have written to express their appreciation after completing their training sessions. Some of these include specific points which made the program rewarding to them. For example:

"This training demonstrated a style of action and conduct I hope to emulate when I eventually begin practice."

"Let me thank those who took time from their private lives after hours to make me feel at home. I enjoyed meeting members of their families and visiting their homes."

"This was a truly rewarding and memorable experience — enough cannot be said about how great everyone was."

"Judging from others, this is the best program for students."

"More importantly, to see physicians in action and to have so many different experiences made it more significant to me."

"Remembering the many doctors who let me examine patients and stand in for procedures will carry me

This cartoon was drawn by Mark Campbell, now a Detroit internist. It depicts his feelings the first day of work in a hospital, when he participated in the AMSA-MECO project.

through the many dry lectures I face in the coming years of medical school."

"It's a fantastic program."

Future plans

MSMS expects the program will continue in future years and may expand. Among the best advocates of continuation are the students who take part. If they talk about their reactions to younger students over the coming year in the same warm tones they use now, there will be more summers of important service.

To participate

It is easy for a hospital to participate in the successful AMSA-MECO program organized by the American Medical Student Association and MSMS.

Hospitals are required to have a program which offers students a chance to learn something about hospital operation and health care delivery, to pay students a modest stipend ($85 per week was recommended this year), and to provide housing for students who work in the program. Students learn at the same time they perform valuable service for the hospital and create good community relations.

For details, contact Mert Scholten, MSMS, 120 W. Saginaw, East Lansing, 48823 or phone 517/337-1351.

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(See more details page 443).

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

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for prescribing information.

Medico-legal

The countersuit: the situation in Michigan today

Midwestern physicians have had a tough time lately filing countersuits against lawyers and plaintiffs in professional malpractice cases. As examples, items on this and the following pages have been gathered for members' special reference by MSMS Legal Counsel A. Stewart Kerr. In addition, he presents other legal actions of special interest.

By A. Stewart Kerr
MSMS legal counsel

Does an Attorney owe a duty to persons other than his client?

That intriguing caption is in the first sentence of the Michigan Court of Appeals' decision of late May, in *Seymour Friedman, M.D. v Peter Dozorc and Robert H. Golden*. Doctor Friedman's litigation is the most prominent of the Michigan attempts to "counter-sue" lawyers who have allegedly filed non-meritorious medical malpractice cases.

Doctor Friedman's countersuit was dismissed in Oakland County Circuit Court without a trial as being without a legal basis or remedy. His appeal to the Court of Appeals has now resulted in a reversal of the lower court. The case can be returned to Oakland Circuit for trial on the merits, but under limited circumstances, or further appealed.

The appellate court analyzed plaintiff's position with respect to the three basic theories of counter-suing these lawyers:

1) Negligence in failing to meet a duty to the doctors to use reasonable care in filing the medical malpractice suit, presumably without full investigation;

2) Abuse of process in using the court system for an improper and ulterior purpose;

3) Malicious prosecution, for lack of probable cause to proceed with the suit, coupled with "malice."

The Court of Appeals reached the conclusion that the doctors' complaint created a question of fact as to whether the defendant lawyers could be found liable for malicious prosecution. The court therefore reversed the lower court and remanded this case for further proceedings on a malicious prosecution claim only.

The court concluded there is no legal basis for grounding Doctor Friedman's case on theories of negligence or abuse of process. Hence, upon the single theory of malicious prosecution, Doctor Friedman now is entitled to try the case on its merits in Circuit Court. The two defendant lawyers may appeal to the Michigan Supreme Court, hoping to sustain the original ruling in the Oakland County Circuit Court and end the litigation. There is a distinct probability that Doctor Friedman will attempt an appeal to the Supreme Court because the Court of Appeals ruling, while an apparent victory for Doctor Friedman, is on the narrow and difficult technical basis of malicious prosecution. Of the three theories, that of malicious prosecution is by far the most difficult to prove. It requires proof of (1) absence of probable cause for the proceeding and (2) "malice." Although the element of "malice" in this tort is difficult to define, it has been held to include a primary motive of ill will or a lack of belief in any possible success. To meet these subjective tests could be an heroic burden for Doctor Friedman to carry.

The Court of Appeals decision is a partial victory and could have a practical, salutary effect in Michigan. This, however, would be at least partly erased if Doctor Friedman goes to trial on a malicious prosecution theory and loses. MSMS is disappointed that Doctor Friedman did not prevail on a theory of ordinary negligence; the Court of Appeals ruling, if it remains the law, may be a poor tool for the medical profession to use in vindicating its members from time to time.

MSMS will monitor the case closely if it goes to Supreme Court. MSMS legal counsel is only mildly optimistic of a broader victory, given the present composition of that Court. MSMS will consider an *amicus curiae* intervention if the filed briefs of the parties appear to warrant or need such assistance.

More about countersuits:

MSMS members should know about a recent ruling in US District Court of Northern Iowa. The court decided a physician has no cause of action, under Iowa law, for malicious prosecution agianst an unsuccessful medical malpractice plaintiff and her attorney, if claims can't be made for "special injuries" beyond those necessarily resulting from malpractice prosecutions. The Iowa rule is similar to that in several other states.

The Iowa court also held the physician has no cause of action against an attorney for negligently advising his client to commence a medical malpractice lawsuit.

The court recognized the physician's feelings that there should be a

(Continued on page 434)

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The procedure by which MSMS decides whether to support a proposed countersuit

(As approved by The MSMS Council and House of Delegates, May, 1976)

The following article details the procedure by which MSMS decides whether to review possible physician countersuits for their merit and possible MSMS support. Further information is available from Mrs. Vada Davis of the MSMS staff (517/337-1351) or from MSMS Legal Counsel A. Stewart Kerr (313/961-0200).

1. MSMS cannot itself bring such a suit; it has no standing in a particular case. However, review and research are accomplished to support or encourage particular aggrieved defendent physicians in bringing a "counter" action.

2. Four conditions must be met, basically, before it can be recommended that an "abuse" suit be filed: 1) suit tried, with no award; 2) malice on the part of the plaintiff or plaintiff attorney; 3) lack of probable cause; 4) demonstrable injury to the defendant doctor. More exotic theories can be examined: abuse of process; barratry, champerty, etc.

3. When a malpractice suit has been filed against a physician which he believes to be totally without merit, that physician should have his defending attorney forthwith advise MSMS in writing of his concurring opinion, forwarding a copy of the Complaint and such defense data as are immediately available. MSMS, by an appropriate committee, will endeavor to make an immediate evaluation as to whether the Complaint and other data disclose any legitimate *medical complaint,* if possible so advising the physician and his defense attorney within 15 days, to the end that a "counter" suit against the patient (only) could be timely filed if deemed appropriate by the defending attorney.

4. When a malpractice suit has been tried to a jury conclusion against plaintiff, MSMS will undertake to assist defendant doctor in evaluating a possible suit against the plaintiff and/or his attorney for having commenced a suit totally without merit. Upon receipt of the full file, including:

a. Copy of complaint.
b. Medical documentation, progress notes, etc., case history.
c. Interrogatories or depositions.
d. Court orders.
e. Names of all attorneys involved.
f. Insurance carriers involved.
g. Information on all parties.

An MSMS committee will make a *medical evaluation.* If the case is found to be devoid of any medical merit, MSMS legal counsel will: make a legal analysis as to whether the proposed action appears to meet the various tests and theories for a new suit (noted above), such as malice, gross negligence in filing

(Continued on page 436)

COUNTERSUITS/continued

remedy for the victim of frivolous litigation and particularly when it casts aspersions on a defendant's professional reputation. "But so far as this court can tell," reads the text of the finding, "Iowa does not recognize reputational harm as a basis for a malicious prosecution action."

In regards to the negligent advice, the court held that "although an attorney owes a general duty to the judicial system, it is not the type of duty which translates into liability for negligence to an opposing party," and that "negligence is an improper standard upon which to base liability of an attorney to an adverse party."

MSMS members may obtain further interpretation from Legal Counsel Kerr in his Detroit offices, 2100 Detroit Bank and Trust Building, 48226.

Illinois ruling

And then, in Illinois, the Appeals Court, First District, Fifth Division, ruled a group of physicians had no cause against an unsuccessful medical malpractice plaintiff and his attorney, and could not "willfully and wantonly" file suit against the attorney for professional negligence.

The Illinois court said the physicians failed to prove there was a wrongful initiation of civil proceedings.

In addition, their complaints about legal malpractice did not hold up. The court said an attorney in Illinois could not be held liable to a former adverse litigant for professional negligence, as such a cause of action "would clearly inhibit free access to the courts."

The physicians further claimed "special injury," one of the elements necessary for a malicious prosecution cause of action, in the form of damage to their professional reputations and an expectation of increased premiums for malpractice insurance.

The court called these contentions "merely conclusions" and "allegations" legally insufficient to constitute "special injury."

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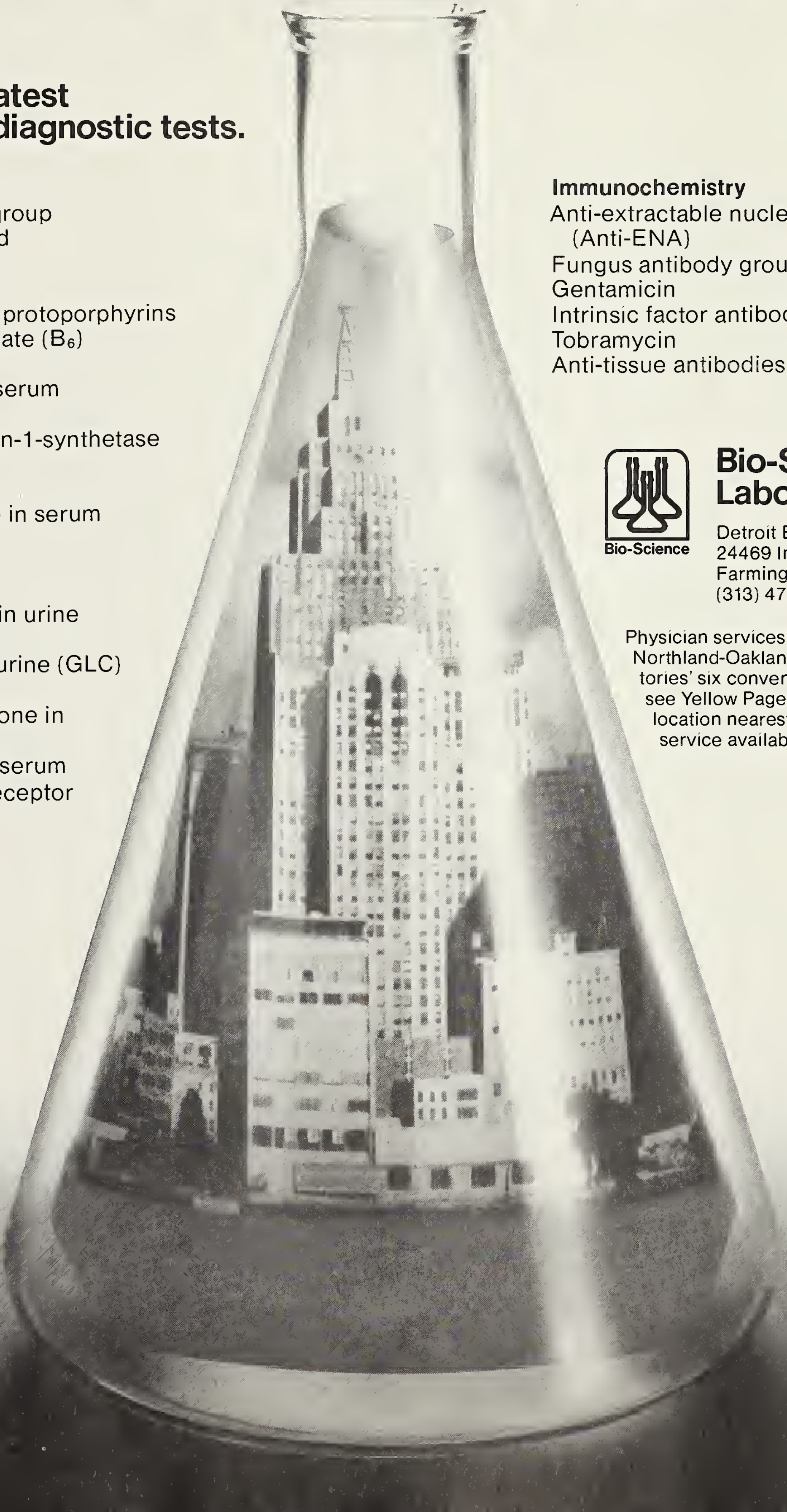

FTC closely watching professionals for antitrust violations

(From the office of MSMS legal counsel)

Doctors, lawyers, and many other professionals will continue to be placed under rigorous examination by antitrust enforcers, according to officials of the Federal Trade Commission and the Justice Department.

The present intense scrutiny of professionals, their trade groups, and state regulators may even increase with the growing interest of state antitrust officials and because of special training being given to U.S. attorneys.

Mark P. Leddy, head of the Antitrust Division's Special Litigation Section, told a recent conference on trade association law & practice that the Antitrust Division currently has about 12 criminal and civil investigations into "professional matters." The impact on local markets of restraints on professionals' activities, he added, is important enough to commit significant Department resources. Recently, the Antitrust Division surveyed 11 professions in all 50 states, and it is "now evaluating those returns," according to Leddy.

Surveillance

Leddy's implied warning to trade association officials was underscored by the head of the Antitrust Division, Assistant Attorney General John H. Shenefield, who cautioned that the likelihood of getting caught by antitrust enforcers is increasing. He also stressed his support of jail sentences for antitrust violators.

Areas of inquiry

Leddy provided some clues to impending Justice complaints. He said there are "a number of significant investigations" of rules restricting the solicitation of business by professionals. The health care area is getting special attention, Leddy said, pointing to restraints on health care professionals about the kinds of salaries and professional business arrangements in which they may engage. "A lot of thinking," but no formal investigating, is being done on prepaid plans for professional services, he said.

Leddy also said "a lot of talk" is underway concerning the "countervailing power issue." In such situations, a group of professionals combine to combat the power of a major corporation. For example, pharmacists may react together when insurance companies place a ceiling on reimbursements which the pharmacists think is unfair. Boycotts by professionals designed to counteract the power of insurance companies or others, even though intended as survival efforts, are "probably illegal," according to Leddy.

Note: The Federal Court at Grand Rapids has reaffirmed that distribution of "prescriptive contraceptives and contraceptive devices to minor, unemancipated children in the absence of notice to, and the opportunity of consultation with, their parents" violates the parents' constitutional rights. Doe v Irwin, 441 F. Suppl. 1247. – A. Stewart Kerr

Warning: If Michigan physicians fail to complete insurance application "physicals" reports within a reasonable time, they are exposing themselves to lawsuits of an explicit damages value, namely the exact amount of the life insurance policy which the deceased (or the injured) did not get issued to him because of the physician's failure to act.

– ASK

MSMS PROCEDURES/*continued*

without investigation, abuse of process, barratry, champerty, etc.; make contacts as needed with the physician and his attorney. If the physician and his lawyer decide to institute the retaliatory action, MSMS will, if requested, endeavor to be helpful by a) supplying names of expert witnesses and b) identifying opposing medical experts as to qualifications and known history of testifying for plaintiff patients.

5. If the "counter" suit goes on appeal, consider *amicus curiae* possibilities.

These Michigan cases detailed in recent AMA publications

Plastic Surgeon Not Guilty of Violating Dental Practice Act, Michigan Court of Appeals, Dec. 22, 1977, from the *Citation*, V. 37, No. 1.

Suit Against MD for Failure to Diagnose Brain Tumor Remanded, Michigan Court of Appeals, No. 9, 1977, from the *Citation*, V. 37, No. 2.

Injured Employee May Sue Workmen's Compensation Insurer for Malpractice, Michigan Court of Appeals, Oct. 25, 1977, from the *Citation*, V. 37, No. 2.

Physicians Sue Insurance Company, Alleging Breach of Contract in Cancelling Policies, Michigan Court of Appeals, Oct. 10, 1977, from the *Citation*, V. 37, No. 2.

Hospital Gets Summary Judgment Based on Governmental Immunity, Michigan Court of Appeals, Sept. 21, 1977, from the *Citation*, V. 37, No. 2.

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Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.
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Physicians can take steps to assure CME programs are worthwhile

By Paul E. Mazmanian
Floyd C. Pennington, PhD
Robert P. Means
Ann Arbor

In recent years much has been written about the ultimate goal of continuing medical education (CME). The World Health Organization (WHO) states that the sole objective of CME is to assist physicians in maintaining and extending their professional competence. Both WHO and the American Medical Association (AMA) indicate that the purpose of continuing education is to improve the quality of preventive and curative care given by physicians.

Sponsors of CME are quick to tell of their responsiveness in facilitating the goals of CME. Repeatedly they point to the quantity of available CME activities, while disregarding the question of whether or not the activities are based on the educational needs of practicing physicians.

The Liaison Committee for Continuing Medical Education (LCCME) and other accrediting agencies require CME program objectives to be based on identified learning needs, but there is reason to believe that many accredited programs are designed undiscerningly or with little regard for the "real" learning needs of physicians.

Med school's role

Medical schools play a significant role in providing CME. Medical school-sponsored CME programs have grown from 626 in 1962-63 to 2,945 in 1977-78. In 1977-78, 113 medical schools were primary sponsors for 40 percent of all accredited offerings.

Ideas for medical school-sponsored continuing education courses originate from: 1) campus faculty and staff suggestions, 2) legislative mandate, 3) project money availability, 4) physician or physician group requests, and 5) formal needs assessments. Even though these and other sources are available to CME planners, primary emphasis is placed upon suggestions from medical school faculty and staff as "expert" opinion.

Experts from faculty and staff of medical schools can indicate to CME program planners their perceptions of practitioners' needs, but to a great extent these assessments are based upon educated guesswork by academic physicians isolated from sites where most program participants conduct patient care. Educational needs of physicians are practice-oriented. Neglect of the physician's self-assessment is disregard of the data source which best reflects the individual's practice setting.

The increasing number of physicians and mandatory CME have triggered a profusion of CME sponsors and a race for accreditation. Since most continuing education divisions must recover all costs, and formal needs assessment can be expensive, CME administrators often order needs assessments which amount to little more than market analyses. These market analyses seek information regarding probable number of participants, degree of satisfaction with past courses, or most convenient time and place for attendance at topic presentations. Such information is valuable to administrators and program planners, but it does not address those gaps in knowledge and skills which physicians must bridge in order to maintain and extend their professional competence.

The temptation of the CME provider is to discount the educational "needs" of physicians in favor of attending physicians' "wants." "Needs" and "wants" are not always the same. For example, a physician may want a course in advanced electrocardiographic (EKG) diagnosis when he actually needs help at the intermediate level, or he may want to participate in an intermediate activ-

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Mr. Mazmanian is research associate; Doctor Pennington is director, and Mr. Means is assistant director, Office of Continuing Education, University of Michigan Medical School.

ity when he needs advanced training. Physicians' learning needs are often knowledge or skill deficiencies. To admit such learning needs may be an uncomfortable task. A physician is naturally inclined toward the comfort of the program he wants, rather than the possibly uncomfortable program he needs.

Physician's responsibility

What can the physician do to ensure that CME activities are relevant?

Both as a learner and a consumer, the physician has an opportunity and a responsibility to assure that CME is based upon clinically relevant needs. The physician is encouraged to subscribe to CME activities in which he assumes an active role in assessing needs and selecting learning activities compatible with his learning style, (e.g., self-assessment examinations or patient simulation exercises). Such self-directed activities reflect practice orientations. Learning needs are identified by comparing current performance with standards of best practice. In the case of self-examination, deficiencies in performance become the foci of subsequent educational activities to which the learner is directed via appropriate literature or formal CME activities. In the case of patient simulation, the exercise constitutes the educational activity.

For CME in which the physician selects a sponsor, such as a medical school or professional society, he must better scrutinize programs. It is unlikely the physician is privy to information regarding whether or not, or what type of needs assessment was used in determining course content and design. However, the physician can review a program for the purpose of determining compatibility with needs by noting the following from course descriptions or brochures:

1. Who planned the course? Was it one or two medical school faculty, or a committee consisting of faculty as well as other practitioners?

2. Does the course content emphasize a review, update, or both? Which of these emphases is most appropriate to the individual's current level of performance?

3. What learning formats are offered? Are there opportunities for independent study . . . self-assessment exercises? Are there ample opportunities for course participant discussion, debate, and individual or group questions and answers? Are there opportunities to test performance, (e.g., workshops or patient simulation exercises)?

The physician has a major responsibility for selecting continuing education programs that are likely to be clinically relevant. But can the physician be sure his/her educational needs are being met by CME program offerings? To the extent the physician assumes an active role in the educational process from need identification to measurement of outcomes, the CME activity is likely to represent learner needs rather than wants, and facilitate rather than obviate physician learning.

Burns Clinic medical meeting Sept. 30

Michigan physicians are invited to enroll for the 6th Annual Medical Meeting sponsored by the Burns Clinic Medical Center and the Northern Michigan Hospitals at the Holiday Inn in Petoskey, September 30. Featured guest lecturers will include Jan C. Seski, MD, of Houston, Texas and James C. Sisson, MD, Ann Arbor. The program will provide 6 hours of Category I credit. Interested physicians may obtain a complete program and registration form from Lee R. Brunner, MD, chairman, Burns Clinic Medical Center, Petoskey, MI 49770.

Cancer patients get rehab help in metro area

The State Board of Education's Bureau of Rehabilitation has joined forces with a Detroit-area cancer control program and the team effort is paying off for cancer patients in Oakland, Wayne and Macomb counties.

Working together with Cancer Action Now, the Bureau's counselors have been providing vocational counseling, job training and placement assistance to cancer patients in the tri-county area. The Bureau's Detroit office has eight counselors with special training who help cancer patients cope with the physical problems of cancer and work with employers to return them to the world of work.

Recent success stories for the program include:

- A man supplied with an electrolarynx and a telephone amplifier so he could return to his job.
- A patient who found a sales position after participating in a job-skills clinic sponsored by the Bureau following his surgery.
- A mastectomy patient whose factory job was re-designed to require less lifting.

"We want to make this program better known to physicians so their patients can participate in the rehabilitation program," says State Superintendent of Public Instruction John W. Porter.

Porter said 121 cancer patients are now enrolled in the program.

Physicians, social workers, and cancer patients who want to know about the program may contact:

DETROIT-WAYNE COUNTY AREA — Carole Sheppard, Detroit, 313/256-2406.

MACOMB COUNTY — Diane Martin, Mt. Clemens, 313/776-8300.

OAKLAND COUNTY — Richard Kane, Royal Oak, 313/544-3136.

MSMS Annual Scientific Program Nov. 7-8-9 to start 'with a bang'

CME topics most requested by physicians will be offered to MSMS members at the 1978 MSMS Annual Scientific Meeting, on all three days, Nov. 7-8-9. But extra efforts have been made to select timely topics, expert course directors, and outstanding faculties for the first day, Tuesday, Nov. 7.

"If starting with a bang is the way to draw a good attendance, then the Tuesday, Nov. 7 explosion should bring many physicians to the Detroit Plaza," declares Carl F. Hammerstrom, MD, Marquette, chairman of the MSMS Committee for CME Programming.

"We want to assure Michigan physicians that the Tuesday line-up is the strongest one-day program ever planned in Michigan," stresses Robert F. Wilson, MD, Detroit, the program chairman.

Course directors outstanding in their fields

Doctor Wilson continues:

"Each of the course directors has a reputation and special interest in the subject that he will present. The deans and department heads of the three Michigan medical schools are cooperating to the utmost to give us the best doctors available as course directors and speakers for Tuesday — and for the full three-day event. For Tuesday, doctors like George Royer, MD, and Edward Cotton, MD, both of Kalamazoo, were carefully selected by specialty groups to join the Scientific Meeting honor roll of course directors."

"The MSMS schedule of courses on Tuesday, Nov. 7 will really be a series of 'mini-conferences,' several of which could draw several hundred doctors. The half-day programs on hypertension, diabetes, renal failure, care of the elderly, coronary artery disease, etc., are all subjects of considerable concern to a broad cross-section of practicing physicians. These large conference-type courses are possible because the Plaza Hotel was able to make some of the larger rooms available on Tuesday," explains Doctor Wilson.

"We are making a strong appeal for physicians to come early on Tuesday, attend two courses and stay overnight for additional courses on Wednesday and for more on Thursday. Too often a physician will come only on Wednesday or Thursday whenever he has an afternoon away from the office," Doctor Hammerstrom stresses.

Detroit Plaza Hotel exciting new location

Doctor Hammerstrom continues:

"MSMS members are indeed fortunate to have such an excellent three-day program available for them in an exciting new location (the Detroit Plaza) and available at such a nominal tuition. Many of the national specialty societies and the AMA present the same type of programs for tuition fees that are more than double the MSMS fees."

The Scientific Meeting will feature 24 courses on Wednesday, Nov. 8, and 22 courses on Thursday, Nov. 9.

The MSMS Council has set the tuition for MSMS members at $4 per credit hour or $12 for a half-day, three-hour course. House officers will be permitted to attend free of charge. Non-member physicians will be charged $8 per credit hour. The MSMS Council contributes $30,000 in staff time to this project, but the budget provides that the tuition income and exhibit sales will cover the cash outlays for speakers' honoraria and expenses, postage, printing, coffee breaks, and audio visuals. The total budget is $60,778, not including the $30,000 for staff salaries.

Courses cost $4/hour for members; $8/hour for non-MSMS members

Michigan physicians who are not members of MSMS but belong to specialty societies will be required again to pay non-MSMS member tuition rates at the 1978 MSMS Annual Scientific Meeting, Nov. 7-8-9 at the Detroit Plaza.

Many specialty societies are cooperating with MSMS to present half-day courses for MSMS members. But these courses are not open at special tuition rates to any specialty society physicians who do not belong to their component society and MSMS.

MSMS members will be charged $4 per credit hour at the 1978 Scientific Meeting and non-members will be charged $8 per hour. The MSMS Council believes this is justified because the Scientific Meeting is a member benefit. The MSMS Council will invest more than $30,000 in staff salaries in this big CME project, those funds coming from dues paid by MSMS members. Leaders feel it is not appropriate for non-MSMS members to enroll in Scientific Meeting courses unless they pay higher tuitions than charged the MSMS members.

The specialty societies cooperating to present courses at the Annual Scientific Meeting all receive funds from the tuition income to bring in out-of-state speakers. Funds from the tuition income pay speakers honoraria and expenses.

Practical topics of wide appeal slated for Tuesday, Nov. 7 with excellent course directors, speakers coming for fast start

All Courses will be for three hours of Category I credit.

Tuesday Morning (8:30 to Noon)

☐ "Newer Developments in the Evaluation and Treatment of the Hypertensive Patient." *Director: Charles P. Lucas, MD, Department of Internal Medicine, Wayne State University School of Medicine.*

☐ "Management of Diabetes Mellitus — Problems in Acute and Chronic Care." *Director: Sumer Pek, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "Sex and the Heart Patient." *Director: Mario Petrini, MD, Department of Obstetrics and Gynecology, Wayne State University School of Medicine.*

☐ "It's Now Easy to Recognize & Manage Chronic Obstructive Pulmonary Disease." *Director: John G. Weg, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "What's New and Practical in Peripheral Vascular Surgery." *Director: James C. Stanley, MD, Department of Surgery, University of Michigan Medical School.*

☐ "Basic Cardiac Life Support." *Director: Don Anbe, MD, Department of Cardiovascular Medicine, Henry Ford Hospital.*

☐ "Common Pitfalls in the Management of Malignancies." *Director: Vainutis K. Vaitkevicius, MD, Department of Oncology, Wayne State University School of Medicine.*

Tuesday Afternoon (1:30 to 5:00)

☐ "What's New in Anti-Arthritics, Beta-Blockers, Bronchodilators, Vasodilators — With Special Attention to New Agents and Drug Interactions." *Director: George L. Royer, Jr., MD, Kalamazoo, for MSMS Section on Clinical Pharmacology.*

☐ "Alcohol and Medical Practice." *Director: Russell F. Smith, MD, Brighton, for MSMS Committee to Assist Impaired Physicians. Sponsored also by Michigan Psychiatric Society, Michigan Chapter of American Geriatrics Society, and Michigan Chapter of American Medical Society on Alcoholism.*

☐ "Care in the September Years." *Director: Edward Cotton, MD, Kalamazoo, Sponsored by Michigan Academy of Family Physicians.*

☐ "Assessment and Management of the Patient with Acute and Chronic Renal Failure." *Director: Gilbert H. Mayor, MD, Department of Internal Medicine, Michigan State University College of Human Medicine.*

☐ "Sexuality: New Recognition Or Another Perspective of an Old Subject." *Director: Charles J. Danek, MD, Department of Physical Medicine and Rehabilitation, University Hospital, Ann Arbor. Sponsored by Michigan Society of Physical Medicine and Rehabilitation.*

☐ "Current Trends in Coronary Artery Bypass Graft Surgery." *Director: Bertram Pitt, MD, Department of Internal Medicine, University of Michigan Medical School.*

☐ "What's New and Practical in Office Endocrinology." *Director: Subhash Gulati, MD, Department of Internal Medicine, Wayne State University School of Medicine.*

* * *

57th Annual Beaumont Lecture, Tuesday Evening, November 7, 1978. Sponsored by Wayne County Medical Society

☐ "Current Trends in Gastroenterology." *Speaker: Howard M. Spiro, MD, Section of Gastroenterology, Yale University School of Medicine.*

Annual MSMS meeting

Detroit, Nov. 7-8-9,
MICHIGAN STATE
MEDICAL SOCIETY

Combine a mini-vacation at the fabulous Detroit Plaza with your participation at the 1978 MSMS Annual Scientific Meeting November 7-8-9. The spacious Plaza will attract 1,500 physicians and their spouses for the 57 Category I courses to be offered. And the Renaissance Center features many designer boutiques and great restaurants so you can combine business with pleasure.

See this issue for details about the courses and a handy registration form.

Category I courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Aug. 21-Aug. 26, **Fifth Regional Congress of the International College of Surgeons. Location:** North Detroit General Hospital, Detroit. **Sponsor:** North Detroit General Hospital. **For:** Surgeons. **Contact:** M. O. Cantor, MD, 4850 Charing Cross Road, Bloomfield Hills, 48013, 313/646-3320. **Approved for:** 45 hours of Category I Credit.

Date: Aug. 25-28, **Infectious Diseases. Location:** Mackinac Island. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family Physicians, Internists. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Aug. 30, **Hematology and the Family Physician. Location:** Edward W. Sparrow Hospital, Lansing. **Sponsor:** Dept. of Family Practice, E. W. Sparrow Hospital, and the Michigan Academy of Family Practice. **For:** Family physicians. **Cost:** None. **Contact:** Richard W. Pomeroy, MD, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48909, Ph: 517/487-2511. **Approved for:** 4 hours of Category I Credit.

Date: Sept. 11-13, **The Neck, Shoulder and Upper Extremities in Sports. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** American Academy of Orthopaedic Surgeons. **Cost:** $150, AAOS members; $200, non-members. **Contact:** American Academy of Orthopaedic Surgeons, 430 N. Michigan Avenue, Chicago, 60611. **Approved for:** 18 hours of Category I Credit.

Date: Sept. 13, **Third Annual Renal Disease Conference. Location:** Kalamazoo Center, 100 West Michigan, Kalamazoo, 49006. **Sponsor:** Michigan Nephrology Center. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Surgeons, Pediatricians, Internists, General Practice, Nephrologists. **Cost:** $35. **Contact:** Jeffrey Block, M.D., Michigan Nephrology Center, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 13-14, **Advanced Cardiac Life Support Course. Location:** Kalamazoo Center Inn, Kalamazoo. **Sponsor:** Bronson Methodist Hospital. **Co-Sponsor:** American College of Emergency Physicians, Michigan Heart Association and the Southwestern Michigan Area Health Education Center. **For:** All specialties. **Cost:** $200. **Contact:** Jon Dixon, Director, Ambulatory Services, Bronson Methodist Hospital, 252 East Lovell Street, Kalamazoo, 49007, 616/383-7895. **Approved for:** 14 hours of Category I Credit.

Date: Sept. 19-22, **Blood Coagulation. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Medical Technologists, pathologists. **Cost:** $225/$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakwood Hospital, Dearborn
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City State Hospital Traverse City
V.A. Hospital, Battle Creek
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: **Sept. 21-23, First Annual Human Development Seminar, "Solving Difficult Problems in Ambulatory Pediatrics: A Multidisciplinary Approach." Location:** Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** Michigan State University Department of Human Development in cooperation with Continuing Education Service. **For:** Primary care physicians in pediatrics. **Contact:** Conferences and Institutes, 50 Kellogg Center, MSU, East Lansing, MI 48824. **Approved for:** 16 hours of Category I Credit.

Date: Sept. 21, 22, 23. Implant Surgery for Joints and Tendons in the Hand. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Cost:** $200. **Contact:** Alfred B. Swanson, MD, Chairman, 290 Blodgett Professional Bldg., Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 23-24, Current Concepts of Respiratory Care. Location: Sugar Loaf Mountain. **Sponsor:** Michigan Society of Anesthesiologists and Wayne State University School of Medicine. **For:** Practicing anesthesiologists. **Cost:** $100. **Contact:** Wayne State University School of Medicine, Div. of CME, 540 E. Canfield, Detroit, 48201, 313/577-1180. **Approved for:** 9 hours of Category I Credit.

Date: Sept. 27, "Will My Drinking Hurt My Baby?" A symposium on the Fetal Alcohol Syndrome. Location: Ann Arbor. **Sponsor:** University of Michigan Medical Center, Neuropsychiatric Institute. **For:** All specialties. **Cost:** $50. **Contact:** Suzanne Gilbert, G1109 Towsley Center for Postgraduate Medical Education, Ann Arbor, 48109, 313/763-0081. **Approved for:** 8¼ hours of Category I Credit.

Date: Sept. 28, J. L. Wilson Symposium. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians. **Cost:** $30. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 5 hours of Category I Credit.

Date: Sept. 28-29, Coping with Changes in the Later Years. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

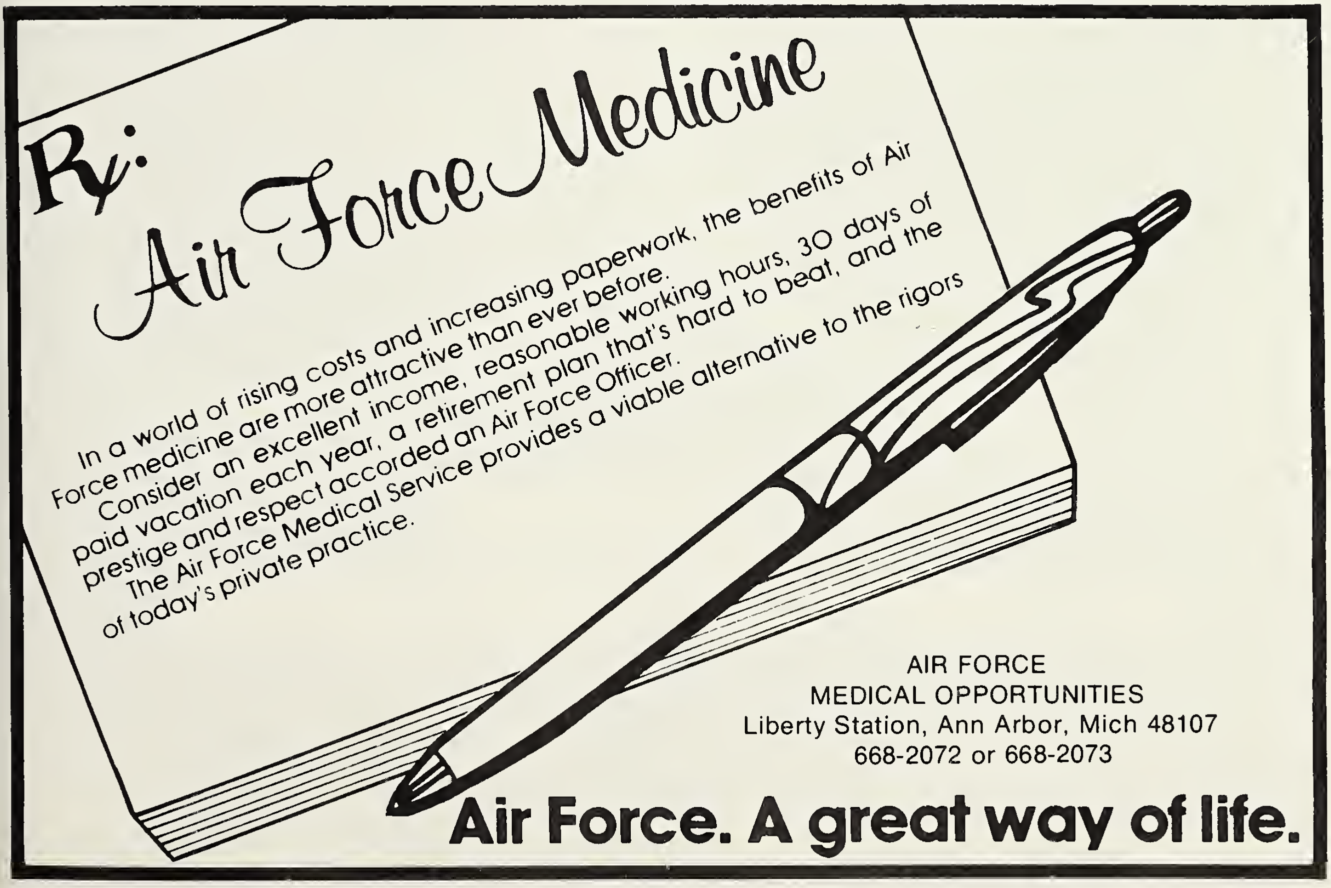
Date: Sept. 30, 6th Annual Medical Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center/Northern Michigan Hospitals, Inc. **For:** Family physicians. **Cost:** (Undetermined). **Contact:** Lee R. Brunner, MD, Burns Clinic, 560 W. Mitchell St., Petoskey, 49770, 616/347-7000, ext. 500. **Approved for:** 6 hours of Category I Credit.

Date: Sept. 30, Michigan Society of Pathologists September Seminar, "Cardiovascular Diseases." Location: Sinai Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: Oct. 3, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 6, 7, 8, Annual Meeting, Michigan Chapter of the American College of Physicians. Location: Otsego Ski Club, Gaylord. **Sponsor:** Michigan Chapter, American College of Physicians. **Contact:** Boy Frame, MD, FACP, ACP Governor for Michigan, 543 Lakepointe, Grosse Pte. Park, 48230. **Approved for:** 12 hours of Category I Credit.

(Continued on page 448)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"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported: Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. Blood: Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred. Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Gastrointestinal: Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported. Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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CATEGORY I/*continued*

Date: Oct. 12-13, **Infectious Diseases & Related Problems. Location:** Kalamazoo Center Inn, Kalamazoo. **Sponsor:** Southwestern Michigan Academy of Family Practitioners. **Co-Sponsor:** SMAHEC Family Practice Residency. **For:** All specialties. **Cost:** $50. **Contact:** Donald E. DeWitt, MD, 436 Stryker Building, Borgess Hospital, 1521 Gull Road, Kalamazoo, 49001, 616/383-8395. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 15, **"Dealing with Alcoholic Patients: Training for Primary Care Clinicians." Location:** Traverse City. **Sponsor:** University of Michigan Medical Center, Neuropsychiatric Institute. **For:** Primary care physicians. **Cost:** $25. **Contact:** Michael R. Liepman, MD, University Hospital, 1405 E. Ann Street, #N2727, Ann Arbor, 48109, 313/764-0170. **Approved for:** 5 hours of Category I Credit.

Date: Oct. 16-20, **Family Practice Review. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: Oct. 18, **Diabetes for the Clinician. Location:** Kalamazoo Center, Kalamazoo. **Sponsor:** American Diabetes Association, and The Upjohn Company. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Family physicians and internists. **Cost:** $25 physicians, $10 house officers. **Contact:** C. L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 252 East Lovell Room 364, Kalamazoo, 49006, (616) 383-6360. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 21, **Regional Infectious Disease Symposium — V.D. Location:** Hurley Medical Center, Merliss Brown Auditorium, Sixth Avenue & Begole Street, Flint, 48502. **Sponsor:** Hurley Medical Center. **For:** All specialties. **Cost:** $30. **Contact:** Richard D. Garlick, Director of CME, Hurley Medical Center. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 25, **Brief Psychotherapy. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, psychotherapists. **Cost:** $50/$30. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 27-28, **Otorhinolaryngology. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otolaryngologists. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12 hours of Category I Credit.

Date: Nov. 2, **Second Annual Michigan Family Practice Research Day. Location:** MSU University Club, East Lansing. **Sponsor:** Department of Family Practice, MSU College of Human Medicine, and Michigan Academy of Family Physicians. **Contact:** Doug McKeag, MD, Chairman, Research Day Planning Committee, MSU Department of Family Practice, East Lansing, 48824, 517/353-00850. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 6-8, **Minimal Breast Cancer. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists, surgeons, hematologists. **Cost:** $160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: November 6-10, **Counseling Older Adults and their Families; Principles of Milieu Therapy: Working with the Elderly in Treatment Settings. Location:** University of Michigan. **Sponsor:** Institute of Gerontology, University of Michigan. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 3.5 hours of Category I Credit.

Date: Nov. 7-9, **MSMS Annual Scientific Meeting. Location:** Detroit Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** MSMS. **For:** All specialties. **Cost:** $4/credit hour for members; $8/credit hour for non-members. **Contact:** Herbert Auer, MSMS headquarters, 517/337-1351. **Approved for:** 20 hours of Category I Credit.

Date: Nov. 13-14, **Oncology-Hematology. Location:** Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Primary care physicians. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Nov. 17-18, **Medical-Surgical Pediatrics. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians, surgeons. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Dec. 5, **Continuing Pathology. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Jan. 18-20, **Rheumatology. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Rheumatologists, internists, family physicians. **Cost:** $150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: Feb. 4-9, **Family Practice Update. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $200. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: **Feb. 15, Continuing Pathology.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: **Feb. 19-23, Emergency Medicine.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians, internists, emergency physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 35 hours of Category I Credit.

Date: **Feb. 27-28, Psychophysiologic Illness.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, primary care physicians. **Cost:** $100. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: **March 6-9, Hematology Review.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Hematologists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: **March 14-16, Advances in Pediatrics.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians. **Cost:** $160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: **April 16-20, Family Practice Review.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME. 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: **April 24, Continuing Pathology.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: **May 10-11, Ophthalmology.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12 hours of Category I Credit.

Date: **May 14-18, Head and Neck Oncology.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otorhinolaryngologists, surgeons. **Cost:** $500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: **May 21-25, Advances in Internal Medicine.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Internists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: **June 7-8, Blood Banking.** **Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $90. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't of PGM/HPE, Ann Arbor, 48109, (313) 764-2287.

**WSU Division of CME, Room 1206, Scott Hall, 540 E. Canfield, Detroit, 48201 (313)577-1180.

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

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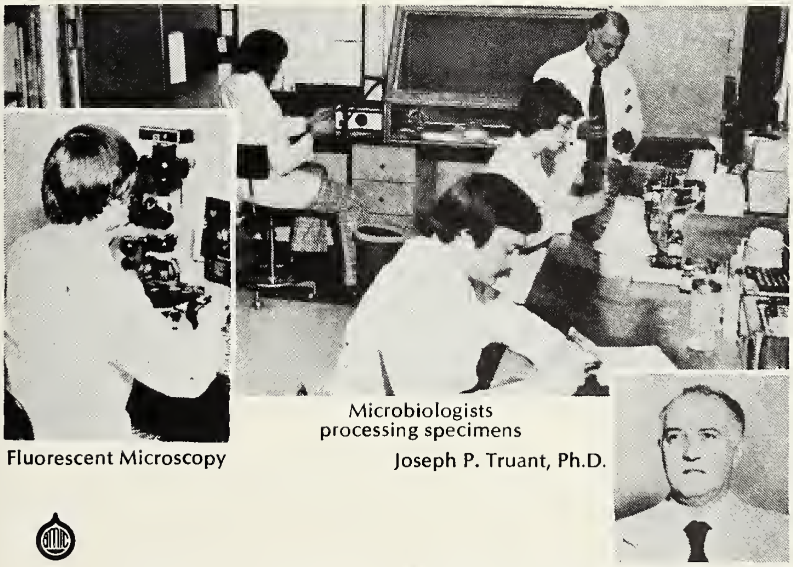

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Views

Auxiliary calling for MDs' spouses to join, learn, and contribute

By Ruth K. Dixon
Grand Rapids

Doctor, organized medicine has a resource worth mining with great potential for public good . . . the Michigan State Medical Society Auxiliary. In this age of growing distrust and animosity toward the profession you love, it is imperative that your wife/husband be encouraged to translate your concern, compassion and commitment into action programs as an auxiliary volunteer. As the American public looks to the medical profession to help solve the complexities of life's problems and because the auxiliary purpose is to extend and enhance your community efforts, we are exceedingly conscious of our unique position of responsibility as doctors' spouses.

Potential members

Traditionally, the medical auxiliary has fostered a deep sense of community involvement through volunteer opportunities. In our positive outreach of caring and sharing, we have put emphasis on surveying and evaluating community needs and implementing relevant projects. Yet, despite our considerable achievements, dedication, devotion and constancy of purpose for over 52 years, we are mindful of a vast, untapped reserve of potential members with whom we are not communicating effectively, if at all.

Fully half of Michigan's counties do not share the advantages of organized auxiliaries and are thereby denied the benefits that accrue from an opportunity at self-expression and representation as concerned and active citizens on the doctors' behalf. The few exceptions are the M-A-Ls (members-at-large who are direct state and/or national members) in said unorganized counties who can, and often do, act as individual catalysts in effecting needed change.

At a time when the state medical society is fortifying its stance with increased membership, it is disconcerting that its auxiliary is far outpaced with an almost-parallel recruiting list. In fact, the disparity is greater than three to one (3-1).

We recognize the interdependence, worth and integrity of our membership. We want, need and value every member and potential member (including the junior affiliate, the spouse of an intern, resident or fellow), mindful that everything is accomplished by the individual through mutual participation. We recognize a reservoir of shared, visible concerns, representing diverse interests which can be unified and magnified by collectiveness. We also work with other community groups for more public awareness and strengthened relationships.

Community leadership

Medical auxiliary accepts a coequal role with physicians in guiding the community in health education efforts that focus on people's lifestyles, behavior and attitudes. The preventative approach seems to offer the greatest possibility for improving health in this country and thus to restore the trust and confidence the medical profession deserves. In other pursuits, we have involved ourselves in politics, in raising monies for medically-related scholarships and in other people-oriented causes. Always, and importantly, we do these things with the approval and/or assignment from the medical society.

We are working to enlist the support of all doctors' spouses. By increasing awareness among ourselves and the public, we continue to educate ourselves and each other for lives of useful service. Ideally, auxiliary desires input and interaction from a member. However, the mere contribution of dues ($5 state, $7 AMA Auxiliary and a variable amount dependent on an individual county) represents a tacit commitment to the objectives of the auxiliary and is gratefully accepted.

Can we depend on your spouse to join the auxiliary, doctor? Please contact your county auxiliary president for details, or write Mrs. Dean Carron, State Membership Chairman, 2756 N. Wagner Road, Ann Arbor, 48103.

Mrs. Dixon is a past president of the MSMS Auxiliary.

Mrs. Dixon

MDs have chance now to work with the Blues

By Roy J. Gerard, MD
East Lansing

Much time, effort and energy has been expended over the past several years regarding economic issues concerning doctors and their patients. The Michigan State Medical Society has been on one side of this issue and the Blues, including representation of labor and industry, on the other. The medical education establishment has alternated sides depending on what was politically expedient at the time and with much emphasis on the dollar subsidy.

Precious time has been lost and the resulting effects are that the image of the doctor has been tarnished and the credibility of the Blues has been challenged by consumer groups, labor and the state insurance commissioner, etc.

The result is that we all lose — and that we can't afford.

One side says the Blues are responsible for these problems. The other side says the medical societies are responsible. We could go on and on making allegations against one another but that will gain us nothing.

It is my opinion that we must try again. We have the responsibility to our patients and to our colleagues to work out alternative methods in health care delivery.

Cost containment has become a national issue and will continue to threaten all of us if we fail to take the initiative in finding solutions.

I feel we have a real opportunity in Michigan to come together, with leadership from MSMS, and from Blue Cross Blue Shield, to find answers that will lead to better care for our patients and restore a dynamic relationship between organized medicine, the private health insurance carriers, and the consumers. This could be a model of health for the nation, and preserve for our future physicians the heritage of the free enterprise system that has made this nation and American medicine a model envied by all. Time is running out.

Blue Shield was spawned in the 1930's by MSMS and became "the Doctor's Plan." MSMS gave it to the Blues in the early 1970's and it became the Blues' Plan. We now collectively have an opportunity to make it the People's Plan.

Doctor Gerard is chairman of the Department of Family Practice, College of Human Medicine, Michigan State University.

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Michigan's mental health system:

Community services, legal issues are key features of sixties, seventies

The following is the second in a three-part series on Michigan's public mental health care system prepared by Doctor Smith in cooperation with the staff of the Michigan Department of Mental Health. The first article, appearing in the May issue, summarized historical trends and developments during the 1940's and 1950's. This article concentrates on current public policy issues and developments of the 1960's and 1970's.

By Donald C. Smith, MD
Ann Arbor
(In cooperation with the Michigan Department of Mental Health)

The Sixties: new alternatives

On the final day of 1960, the Joint Commission on Mental Illness and Health transmitted its now classic report, "Action for Mental Health," to the Congress.

The report, six years in the making, and the most comprehensive examination of the field in the nation's history, called for:

— expansion of basic and applied research efforts directed at mental illness;

— development of outpatient and inpatient programs to provide immediate care for acutely disturbed patients;

— initiation of a network of community-based after-care services;

— greater emphasis on a program of public education;

— launching of a national manpower recruitment and training effort;

— tripling of expenditures for mental health during the subsequent 10-year period.

Through its directness and simplicity of language, the report captured the attention of the president and Congress, governors and legislators, and — most importantly — the American people.

On October 17, 1961, John F. Kennedy named a President's Panel on Mental Retardation and directed the members to prepare by the close of 1962 a national plan to combat mental retardation.

In Michigan, the era of the isolated mental health institution was drawing to a close. The most dramatic development of the decade was emerging, a development which would irrevocably alter its public mental health system.

The drama began with passage of the community mental health services act, (P.A. 54, 1963) on April 29.

The new Act was enabling and permissive. It authorized county governments to establish and operate a broad spectrum of mental health services with supporting grants from the state. Eligible for funding under the act were: consultation services, information and education services, outpatient diagnostic and treatment services, inpatient treatment, and rehabilitation services.

Acceptance of the program by the counties was rapid. By the end of the decade, more than 30 boards, serving areas with 90 percent of the population of the state, were in operation providing a broad range of services. The original state appropriation for community mental health services, about $1 million in fiscal 1964-65, grew to $13 million at the close of the decade.

In a related development, the congress in 1963 passed the first of a series of public laws and appropriations designed to expedite establishment of a national network of comprehensive community mental health centers. Under terms of the statutes, these funds could be provided for construction and/or staffing of the centers.

During the next 10 years, Michigan received federal funds to assist in construction of 12 comprehensive community mental health centers. Sixteen staffing grants were approved.

Actions were also being taken by the Michigan Department of Mental Health to improve state services for emotionally disturbed children.

Specialized units for children were provided at the newly-constructed Northville State Hospital and at Lafayette Clinic in Detroit. A hospital designed exclusively for children, Hawthorn Center, was opened near Northville. Comprehensive children's units also opened in four of the state hospitals.

Concurrently, the department initiated efforts on behalf of the mentally retarded.

To provide an alternative to institutionalization, the first of a network of community day training programs for the severely mentally retarded was opened in 1964. This center, and the ones which followed, served children excluded from local school programs.

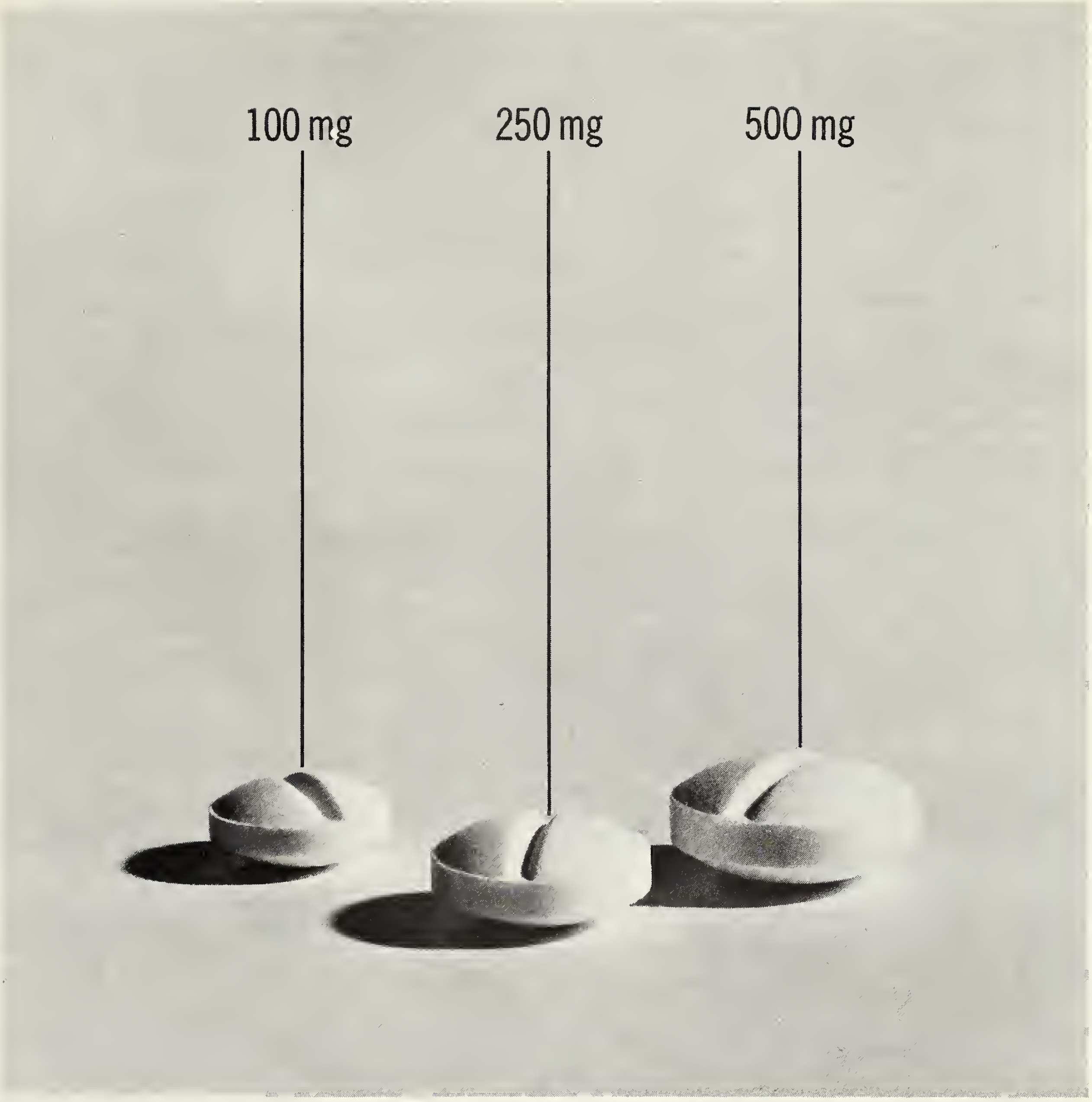
To serve severely retarded adults, action was initiated in the latter half of the sixties to establish a series of activity centers.

By the end of the decade, nearly 60 day centers were operational throughout the state, serving more than 1,200 mentally retarded persons. Budget for the centers was more than $2.5 million.

New small regional centers for the mentally retarded were opened in Muskegon, Gaylord and Howell.

(Continued on page 454)

Doctor Smith was director of the MDMH from 1974 to 1978 and now is professor of maternal and child health, and pediatrics at the University of Michigan.



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In brief, expansion of state services and development of local services under Michigan's Public Act 54, coupled with a new initiative from Washington, resulted in creation of mental health resources which could not have been imagined at the beginning of the decade.

Patient population in the state psychiatric hospitals dropped from nearly 19,000 in 1960 to 11,000 in 1970. New treatment techniques, primarily the increasingly sophisticated psychotropic drugs, coupled with increases in staff-patient ratios, and a vastly increased array of alternatives to inpatient treatment had altered Michigan's mental health system irrevocably.

The Seventies: civil rights

Mental Health in the seventies shifted gears; there was less emphasis on bricks-and-mortar; more on patient rights, legal issues, and new treatment techniques. The question was not how to feed and clothe and house another 100 persons but rather how to intensify and improve quality of treatment, secure accreditation, strengthen support services for those leaving the institution, meet new legal mandates, and integrate and coordinate new community treatment efforts with ongoing programs of the state inpatient units.

As community mental health boards strengthened existing services and developed new services, often with the active participation of local physicians, the ability of local communities to provide help for patients with milder psychiatric disorders was slowly but steadily expanded.

Superimposed on this intense activity to move toward an integrated system of hospital and community care and treatment were a series of complex legal actions.

The right to treatment and the right to refuse treatment, the right of due process to be free of involuntary confinement and the right to be treated in the least restrictive environment — these issues and more were the natural outgrowth of the general civil rights and consumerism movements sweeping the country in the late sixties and on into the seventies. The requirement to adjust to these societal and legal demands constitutes the dominant feature of the public and private mental health systems in the seventies.

As the decade opened, Michigan's statutes with regard to the mentally ill and mentally retarded were an odd compendium of statutes enacted over a fifty-year period. Calls to recodify these laws had been heard throughout the sixties.

After years of work and declaration by the federal court in Detroit that Michigan's commitment statute was unconstitutional, a new state mental health code was signed into law. It has been referred to as "landmark legislation" and it is, in fact and in designation. It is a complex piece of legislation requiring the Department to:

(1) Promote the availability of comprehensive care and treatment services for the mentally ill and mentally retarded, and;

(2) Fully protect the rights of the individual. With regard to commitment procedures, the Code requires notice of hearings, the right to counsel, the right to be present at hearings, the right to communicate with family, friends or lawyers during the procedure.

In addition to the due process rules, the new statute contains over 20 rights to be guaranteed to recipients of mental health services including the right to services suitable to his condition.

To expedite development of community programs, financing for Michigan's county mental health programs was boosted from a 75/25 state-local match formula to 90/10.

Another important change was in the new commitment procedure and its requirement that alternatives to hospitalization be reviewed by the court and, when appropriate and possible, treatment be provided in mental health centers, day care facilities, and extended care facilities.

There are implications here for practitioners in private practice and those working under contractual agreements with community agencies. The court, in most cases, will not order hospitalization if there is a rational and viable alternative.

With more than 50 private psychiatric units in Michigan currently licensed and operating, the service delivery impact of these units is now substantial.

In a span of less than 20 years the number of private psychiatric hospitals and psychiatric units in general hospitals has doubled and the community hospital has become a primary resource for persons requiring psychiatric services. State regional psychiatric hospitals have assumed an appropriate role as back-up resource providing specialized services.

Following extensive review of various options, the Department in August, 1976, announced a series of actions to decentralize decision-making responsibilities and provide more effective clinical and administrative services.

The steps included: creation of five regions, each headed by a deputy director of the Department. The deputy directors were given responsibility for determining regional service demands and resource requirements, preparing regional budgets, appointing heads of state agencies in the region, and other broad policy, supervisory and administrative matters.

Summary

Mental health programs in Michigan have advanced dramatically in the last quarter-century. Modern treatment methods, delivery of selected services at the local community level, and establishment of a statewide integrated service delivery system are just a few of the advances which made this possible.

The stage is set for the challenges certain to be features of the eighties — full participation in quality assurance programs, additional progress toward the provision of mental health services as part of, instead of apart from, general health services, and, hopefully, new scientific breakthroughs such as discovery of a methodology to eliminate schizophrenia, and more advanced techniques to reduce the incidence of retardation.

What is certain is that the private medical community will continue to have an ever-increasing involvement in the delivery of mental health services. In this increased involvement, the community's primary care providers will have a central role.

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Pontiac MDs describe medicine to radio audience

By C. R. Shelton
Special to Michigan Medicine

The above photograph was made during a broadcast of "Prognosis" while Al Wolf (left), Everette Gustafson, MD (middle), and Rockwood W. Bullard, Jr., MD, discussed vasectomies. A portion of that program was taped prior to the show as a vasectomy was in progress.

If you are driving in the Pontiac area on a Friday afternoon between five and six o'clock, turn your radio to station WPON, 1460 on your AM dial and listen to one of the most unusual documentary radio programs in the area.

What you will hear is a live question and answer program called "Prognosis" which features two or three Oakland County physicians discussing and answering listeners' telephoned questions about a specific medical subject.

Twenty-year history

"Prognosis is aired under the guidance of the Oakland County Medical Society and is the outgrowth of a 30-minute program that was begun about 20 years ago by physicians at Pontiac General Hospital.

Everette Gustafson, MD, Pontiac, was in charge of Oakland County Medical Society's public relations in 1958 and, along with other physicians, started the half-hour, taped, public service talk show which was known as "Stethoscope."

Later, the title was shortened to "Off The Cuff" and was aired 7:30 until 8:00 P.M. every other Thursday. It, too, was taped and was presented by WPON as a public service.

From the beginning of the medically-oriented programs, there has been an anchor-person from the station who acted as moderator, answered calls, and interacted with guest physicians. About two years ago, a WPON newscaster, Al Wolf, became the regular moderator.

While the basics of the show remained the same with Doctor Gustafson persuading articulate physicians to appear and guiding Mr. Wolf in the selection of topics and methods of presentation, the program was greatly strengthened by the continuing presence of a moderator who has a keen interest in medicine and the drive to do extensive research on subjects selected for discussion.

In January of this year the show was lengthened to an hour broadcasted during prime time, and the name was changed to "Prognosis." Advertising time is sold for presentation during the program. However, there is no sponsor, as such.

Some of the subjects covered since "Prognosis" has been aired include: "How to Survive the Flu," "Hormones and Cancer," "Hypertenion," "Vasectomy," and "Teen Age Pregnancy."

Mr. Wolf says he believes one major reason for the popularity of the show is that people sometimes find it easier to talk with doctors over the phone than in person — especially if the subject is one which can cause embarrassment.

MDs participate

During the years the program has been on — no matter what the title may have been — about 100 physicians have appeared. The great majority of those were Oakland County residents.

Planning meetings for the show have spawned ideas for programs other than "Prognosis" that have been presented by WPON. Two of the most popular of these were "The Sounds of Life," a taped show recorded during the delivery of a baby, and "Emergency Room." The latter won a First Place Award for excellence in radio coverage from the Society of Professional Journalists.

Doctor Gustafson states that he helped create the medical programs because he felt physicians should be heard more in their community. The fact that a medical program has continued so long on WPON is very encouraging to him.

"If there is one thing I would suggest to my colleagues, it is to get more involved in community activities . . . whether on the radio, in civic clubs, or wherever. Those of us in the medical profession need to get out of our offices occasionally, and be more available and more vocal."

U-M studies on crib deaths link maternal, fetal antibodies

University of Michigan scientists are inching closer to the cause of crib death.

Earlier this year epidemiologists of the U-M School of Public Health announced they had discovered antibodies in the lung tissues of infants who had died from nontraumatic causes. Children dying suddenly from an accident, a fall, or injury do not show antibodies on autopsy.

It is now believed that mothers of SIDS (Sudden Infant Death Syndrome) may have been exposed to the disease-causing agents before the birth of the infant. This exposure, causing the mother to develop protection (antibodies) against the disease agent (antigen), may make the unborn child disastrously sensitive.

The U-M investigators speculate a parallel between measles and crib death has a "theoretical basis." They do not claim that crib death is caused by measles virus, but rather that maternal exposure to the cause of crib death resembles the hazards of measles during pregnancy.

"It seems highly probable that the mother had contact with the antigen (agent) before the birth of the infant, and, as a result, she developed antibodies (defense). We found antibodies in the blood of both mother and the expired infant," states W. Wilbur Ackermann, PhD, U-M professor of epidemiology and head of the SIDS study.

"There is no evidence, however, that the cause of crib death is a single virus," he adds.

Doctor Ackermann states there are three more critical steps in unravelling the riddle of crib death: to determine whether one or a group of antigens is involved; to provide more precise diagnosis of SIDS; and to try to recognize high risk groups by prenatal examinations.

"One thing is clear from our studies to date: the presence of antibodies proves crib death is not mysterious but caused by specific, even though complex, agents," Ackermann states.

The U-M team includes Nick H. Maverakis, PhD, assistant professor; Warren E. Eveland, PhD, professor emeritus; and Clara Raven, MD, former deputy chief medical examiner of Wayne County.

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Sen. Faust, majority leader, promotes accountability

By Willah Weddon
Special to Michigan Medicine

> *The following article is the seventh in a series. The articles, written especially for* Michigan Medicine *by Lansing-area free-lancers, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.*

"There is a need for laws which will regulate health care providers, curb abuses and assure that everyone in Michigan can afford proper health care," contended Sen. William Faust, majority leader in the State Senate.

The quiet-spoken, affable senator points with satisfaction to the June passage of Michigan's Public Health Code (H.B. 4070) as an example of the way the 79th Legislature has responded to this need.

"This law entitles all Michigan residents to certain basic health services, regardless of their ability to pay," he pointed out. "Its major purpose is to revise, organize and modernize current state laws relating to public health and to eliminate obsolete and conflicting public health laws.

"Under this new law the state's health care regulatory system will become more consumer-oriented and cost conscious," he continued. "Consumers will be members of the professional licensing boards, competency tests will be required of licensed professionals, complaint investigations will be strengthened and the state's authority to discourage the construction of costly and unnecessary medical facilities will be broadened."

Aware of good care

The 49-year-old Senator is keenly aware of the importance of good medical care. He was elected to the office in 1966 while in a hospital bed, and is still confined to a wheelchair, as a result of an automobile accident. He is also politically atuned to the fact that labor union support plays a vital role in districts such as his (the 13th senatorial district), which is composed of a section in Wayne County. Thus, during his almost 12 years in the senate, he has managed to balance the interests of organized medicine and organized labor, without being considered a foe to either of them.

The Democrat from Westland has earned the respect of the colleagues through adherence to duty and detail. Still, many of them were surprised when he was elected majority leader in the current session. Sen. Faust quickly instituted some changes and proposed others which have gained general approval from a previously rather loosely-run senate body. (As a result of his insistence on tighter control of spending by committees, these accounts must now be recorded in the Senate Journal.

Dedicated to accountability

This dedication to openness and accountability extends to his attitude toward all government spending and he points out fraud contributes to the problem of rising health care costs.

"Estimates have placed abuse of Michigan's Medicaid program at $80 million to $160 million annually," he said. "Investigations by federal authorities in 1977 placed fraudulent claims against the Medicaid and Medicare programs in the Detroit area at more than $10 million. These claims involve nursing homes and other related health services." He has been a firm supporter of the Nursing Home Reform bill as well as medicaid fraud legislation (Senate bills 13-26) to help correct such situations.

Sen. Faust

A graduate of the University of Michigan, Sen. Faust did some graduate work at Eastern Michigan University, was publisher-editor of Wayne Dispatch, 1956-60 and managing editor of Associated Newspapers from 1960-63. He held offices in Nankin Township as trustee and supervisor immediately prior to his election to the state senate and has been re-elected each subsequent term.

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Surgeons' charges vary widely, specialty society study shows

A wide range in surgeons' charges around the state is revealed in a recent survey conducted by the Michigan Society of General Surgeons.

The data gathered in the June survey refutes the claims that physicians collectively set fees for procedures. Fees were reported from the three regions established by Blue Cross/Blue Shield of Michigan for their payment programs.

For instance, the surgeons who responded to the MSGS survey reported they charge from $425 to $1,500 for colon resections in Region 1, which includes Macomb, Oakland, Washtenaw and Wayne Counties. The same procedure costs between $350 and $1,000 in Region 2, consisting of Arenac, Bay, Calhoun, Emmett, Genesee, Gladwin, Grand Traverse, Ingham, Iosco, Isabella, Jackson, Kalamazoo, Kent, Lapeer, Livingston, Mecosta, Midland, Monroe, Muskegon, Saginaw and St. Clair counties.

The same procedure in Region 3, which consists of all remaining Michigan counties, costs between $420 and $950.

The survey also measured percentage of participation of surgeons in all regions in Blue Cross/Blue Shield of Michigan programs. In addition, the amount of BCBSM payment of physicians' fees was recorded for 11 common procedures.

Following are some of the results in greater detail:

STATEWIDE SURGEONS' CHARGES

	Low	*High*	*Median*	*Mean*
Hospital Consultation	$ 15	$ 100	$ 45	$ 47
Initial Office Visit	9	40	18	18
Follow-up Visit	1	20	12	12
Appendectomy	250	500	315	341
Bowel Obstruction	275	1,000	500	494
Breast Biopsy	50	400	185	186
Breast Radical	360	1,000	625	635
Cholecystectomy	400	800	545	554
Colon Resection	350	1,500	720	725
Hemorrhoidectomy	132	500	285	279
Inguinal Hernia, unilateral	225	550	310	324
Thyroidectomy	350	1,000	550	577
Vagotomy and Pyloroplasty	450	1,200	638	663
Vein Stripping	192	750	350	376

REGION I SURGEONS' CHARGES

	Low	*High*	*Median*	*Mean*
Hospital Consultation	$ 20	$ 100	$ 50	$ 49
Initial Office Visit	10	35	20	19
Follow-up Visit	7	20	15	13
Appendectomy	250	500	300	352
Bowel Obstruction	300	1,000	500	551
Breast Biopsy	50	400	200	203
Breast Radical	400	1,000	650	670
Cholecystectomy	400	800	550	592
Colon Resection	425	1,500	750	794
Hemorrhoidectomy	132	500	310	300
Inguinal Hernia, unilateral	250	550	325	351
Thyroidectomy	400	1,000	550	601
Vagotomy and Pyloroplasty	500	1,200	650	711
Vein Stripping	192	750	350	379

REGION II SURGEONS' CHARGES

	Low	*High*	*Median*	*Mean*
Hospital Consultation	$ 20	$ 100	$ 45	$ 48
Initial Office Visit	10	40	18	19
Follow-up Visit	1	15	12	12
Appendectomy	250	500	325	340
Bowel Obstruction	300	765	500	461
Breast Biopsy	125	275	175	182
Breast Radical	360	850	623	629
Cholecstectomy	420	750	548	542
Colon Resection	350	1,000	750	692
Hemorrhoidectomy	85	500	275	278
Inguinal Hernia, unilateral	245	525	300	316
Thyroidectomy	360	900	560	580
Vagotomy and Pyloroplasty	450	1,000	638	649
Vein Stripping	200	700	363	386

REGION III SURGEONS' CHARGES

	Low	*High*	*Median*	*Mean*
Hospital Consultation	$ 15	$ 65	$ 40	$ 40
Initial Office Visit	9	35	14	14
Follow-up Visit	8	13	10	10
Appendectomy	250	384	315	320
Bowel Obstruction	275	720	438	463
Breast Biopsy	100	200	163	157
Breast Radical	400	720	565	583
Cholecystectomy	400	655	500	504
Colon Resection	420	950	630	648
Hemorrhoidectomy	150	300	245	233
Inguinal Hernia, unilateral	225	350	292	285
Thyroidectomy	350	576	500	503
Vagotomy & Pyloroplasty	450	700	595	593
Vein Stripping	210	525	338	344

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News

Donald C. Austin, MD, is the new president of the Detroit Surgical Society, and **Robert P. Lilly, MD,** was chosen president-elect.

Thomas M. Batchelor, MD, and **L. Murray Thomas, MD,** are this year's recipients of the Wayne State University School of Medicine's Distinguished Alumni Service Awards.

James Bishop, MD, and **James Lawrence, MD,** spoke about allergy at the final 1977-78 public forum sponsored in Traverse City by the Munson Development Council and the County Medical Society. The series will resume again in the fall.

Maurice Castle, MD, Detroit, was featured recently in the *Detroit Free Press* when Columnist Frank Angelo wrote about the Neuromuscular Institute, which is led by Doctor Castle as part of the Metropolitan Society for Crippled Children and Adults.

Ronald B. Elder, MD, former medical director of the Tri-County Comprehensive Substance Abuse Program, Lansing, is the new medical director for the Motor Wheel Corporation.

David H. Gilbert, MD, Laurium, received a "Michigan Week Volunteer Leadership Award" at a special program in Marshall during the Michigan Week. He was cited especially for his local efforts in upgrading ambulance services.

John W. Henderson, MD, Ann Arbor, was recently chosen vice president of the American Ophthalmology Society. He will assume the presidency in 1979. He is chairman of the University of Michigan department of ophthalmology and a former member of the MSMS House of Delegates.

Doctor Batchelor

Doctor Henderson

Doctor Thomas

Robert C. Johnson, MD, Traverse City, is now the medical director of the Grand Traverse Medical Care Facility, succeeding **William Peterson, MD,** who died.

Hershel Sandberg, MD, Southfield, is now chairman of the medical physicians division of State of Israel bonds, succeeding **Joel I. Hamburger, MD,** of Oak Park.

Lewis E. Simoni, MD, formerly of Flint, is now professor and chairman of the Department of Family Practice at East Tennessee State University College of Medicine at Johnson City, Tenn. A past president of the Genesee County Medical Society, he was a delegate to the MSMS House of Delegates and a former chairman of several MSMS committees.

Alfred B. Swanson, MD, Grand Rapids, was a visiting professor at the hand surgery department of Johns Hopkins University this summer, and he presented papers recently at the Mayo Clinic, Cleveland, San Francisco, Philadelphia, Atlanta and in Florida.

John H. van de Leuv, MD, is the new president of the Michigan Chapter of the American College of Emergency Physicians. **Harvey J. De Maagd, MD,** Grand Rapids, was named president-elect. Doctor van de Leuv is director of the emergency department at Wyandotte General Hospital.

Gerald Zick, MD, Lansing, was saluted in a special Father's Day feature in the Lansing State Journal as a "caring, fatherly physician."

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[†] See Prescribing Information.

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[§] Serious as well as minor side effects have been reported with the use of oral contraceptives. These include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

See the complete Prescribing Information for this product, a summary of which is on the next page.

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ANT NOTE—This information is a BRIEF SUMMARY of the complete prescribing information provided with the product and efore should not be used as the basis for prescribing the product. This summary was prepared by deleting from the plete prescribing information certain text, tables, and references. The physician should be thoroughly familiar with the mplete prescribing information and patient information before prescribing the product.

NDICATION: CONTRACEPTION. The pregnancy rate in women using conventional combination oral contraceptives (containing 35 mcg or more of ethinyl estradiol or 50 mcg or more of mestranol) is generally reported as less than one pregnancy per 100 woman-years of use. Slightly higher rates (somewhat more than one pregnancy per 100 woman-years of use) are reported for some combination products containing 35 mcg or less of ethinyl estradiol, and rates on the order of three pregnancies per 100 woman-years are reported for the progestogen-only oral contraceptives. Table 1 gives ranges of pregnancy rates reported in the literature for other means of contraception. The efficacy of these means of contraception (except the IUD) depends upon the degree of adherence to the method.

Table 1: Pregnancies Per 100 Women Years. IUD, less than 1-6; Diaphragm with spermicidal product (creams or jellies), 2-20; Condom, 3-36, Aerosol foams, 2-29; Jellies and creams, 4-36; Periodic abstinence (rhythm) all types, less than 1-47; 1. Calendar method, 14-47; 2. Temperature method, 1-20; 3. Temperature method—intercourse only in postovulatory phase, less than 1-7; 4 Mucus method, 1-25; No contraception, 60-80. **DOSE-RELATED RISK OF THROMBOEMBOLISM FROM ORAL CONTRACEPTIVES:** Two studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. For this reason, it is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive product prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance. It is recommended that new acceptors of oral contraceptives be started on preparations containing .05 mg or less of estrogen **CONTRAINDICATIONS:** Oral contraceptives should not be used in women with any of the following conditions. 1 Thrombophlebitis or thromboembolic disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.
The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely than nonusers to develop these diseases without evident cause Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age. **CEREBROVASCULAR DISORDERS:** In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4.0 to 9.5 times greater in users than in nonusers.
MYOCARDIAL INFARCTION: An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. In terms of relative risk, it has been estimated that oral contraceptive users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke Oral contraceptive users who are also smokers have about a 5-fold increased risk of fatal infarction compared to users who do not smoke, but about a 10-to 12-fold increased risk compared to nonusers who do not smoke. Furthermore, the amount of smoking is also an important factor. In determining the importance of these relative risks, however, the baseline rates for various age groups must be given serious consideration The importance of other predisposing conditions mentioned above in determining relative and absolute risks has not as yet been quantified; it is quite likely that the same synergistic action exists, but perhaps to a lesser extent **Risk of Dose:** In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Careful epidemiological studies to determine the degree of thromboembolic risk associated with progestogen-only oral contraceptives have not been performed. Cases of thromboembolic disease have been reported in women using these products, and they should not be presumed to be free of excess risk The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events **ESTIMATE OF EXCESS MORTALITY FROM CIRCULATORY DISEASES:** A large prospective study carried out in the United Kingdom estimated the mortality rate per 100,000 women per year from diseases of the circulatory system for users and nonusers of oral contraceptives according to age, smoking habits, and duration of use. The overall excess death rate annually from circulatory diseases for oral contraceptive users was estimated to be 20 per 100,000 (ages 15-34—5/100,000; ages 35-44—33/100,000; ages 45-49—140/100,000), the risk being concentrated in older women, in those with a long duration of use, and in cigarette smokers. It was not possible, however, to examine the interrelationships of age, smoking, and duration of use, nor to compare the effects of continuous versus intermittent use. Although the study showed a 10-fold increase in death due to circulatory diseases in users for five or more years, all of these deaths occurred in women 35 or older. Until larger numbers of women under 35 with continuous use for five or more years are available, it is not possible to assess the magnitude of the relative risk for this younger age group. This study reports that the increased risk of circulatory diseases may persist after the pill is discontinued. Another study published at the same time confirms a previously reported increase of mortality in pill users from cardiovascular disease. The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. The findings of this analysis are shown in Figure 1 below The study concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke (The rates given for pill only/smokers for each age group are for smokers as a class. For "heavy" smokers [more than 15 cigarettes a day], the rates given would be about double; for "light" smokers [less than 15 cigarettes a day], about 50 percent.) The mortality associated with oral contraceptive use in nonsmokers over 40 is higher than with any other method of contraception in that age group. The lowest mortality is associated with the condom or diaphragm backed up by early abortion. The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia and especially by cigarette smoking. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended. Based on the data currently available, the following chart gives a gross estimate of the risk of death from circulatory disorders associated with the use of oral contraceptives:

SMOKING HABITS AND OTHER PREDISPOSING CONDITIONS—RISK ASSOCIATED WITH USE OF ORAL CONTRACEPTIVES

Age	Below 30	30-39	40+	
Heavy smokers	C	B	A	A—Use associated with very high risk
Light smokers	D	C	B	B—Use associated with high risk
Nonsmokers (no predisposing conditions)	D	C,D	C	C—Use associated with moderate risk
Nonsmokers (other predisposing conditions)	C	C,B	B,A	D—Use associated with low risk

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately. A four- to six-fold increased risk of postsurgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization. 2 OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; onset of proptosis or diplopia; papilledema, or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures. 3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver Certain synthetic progestogens, none currently contained in oral contraceptives, have been noted to increase the incidence of mammary nodules, benign and malignant, in dogs. In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. Of the cases found in women without predisposing risk factors for adenocarcinoma of the endometrium (e.g., irregular bleeding at the time oral contraceptives were first given, polycystic ovaries), nearly all occurred in women who had used a sequential oral contraceptive These products are no longer marketed. No evidence has been reported suggesting an increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives. Several studies have found no increases in breast cancer in women taking oral contraceptives or estrogens. One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in the subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented. In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

Figure 1. Estimated annual number of deaths associated with control of fertility and no control per 100,000 nonsterile women, by regimen of control and age of woman.

	15-19	20-24	25-29	30-34	35-39	40-44
No method	5.5	5.2	7.1	14.0	19.3	21.9
Abortion only	2.3	2.5	2.5	5.2	9.8	6.6
Pill only-nonsmokers	1.3	1.4	1.4	2.2	4.5	3.1
Pill only-smokers	1.5	1.6	1.6	10.8	13.4	58.9
IUDs only	1.1	1.2	1.2	1.4	1.6	1.4
Traditional contraception only	1.1	1.4	1.9	3.7	4.7	4.0
Traditional contraception and abortion	0.3	0.4	0.4	0.8	1.4	0.8

4. HEPATIC TUMORS. Benign hepatic adenomas have been found to be associated with the use of oral contraceptives. One study showed that oral contraceptive formulations with high hormonal potency were associated with a higher risk than lower potency formulations. Although benign, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives. Two studies relate risk with duration of use of the contraceptive, the risk being much greater after four or more years of oral contraceptive use. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass or shock. A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time. 5. USE IN OR IMMEDIATELY PRECEDING PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated to be on the order of 1 to 4 in 1000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Male children so exposed may develop abnormalities of the urogenital tract. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes. An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of sex hormones, including oral contraceptives, in pregnancy One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend three months although no precise information is available on which to base this recommendation. The administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy. 6. GALLBLADDER DISEASE. Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives and estrogens. In one study, an increased risk appeared after two years of use and doubled after four or five years of use. In one of the other studies, an increased risk was apparent between six and twelve months of use. 7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives. An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives. 8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives. Hypertension that develops as a result of taking oral contraceptives usually returns to normal after discontinuing the drug 9. HEADACHE The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause. 10. BLEEDING IRREGULARITIES Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. If pathology has been excluded, time or a change to another formulation may solve the problem. Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease. Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods. Postuse anovulation, possibly prolonged, may also occur in women without previous irregularities. 11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. 12. BREAST FEEDING. Oral contraceptives given in the postpartum period may interfere with lactation. There may be a decrease in the quantity and quality of the breast milk Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The effects, if any, on the breast-fed child have not been determined If feasible, the use of oral contraceptives should be deferred until the infant has been weaned. **PRECAUTIONS: General:** 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3 Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug-related 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, asthma, or cardiac or renal insufficiency 5 Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives: a. Increased sulfobromophthalein retention. b. Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. c. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered. d. Decreased pregnanediol excretion. e. Reduced response to metyrapone test **INFORMATION FOR THE PATIENT: [See Patient Package Insert]. DRUG INTERACTIONS:** Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. **CARCINOGENESIS, PREGNANCY, NURSING MOTHERS: See CONTRAINDICATIONS and WARNINGS. ADVERSE REACTIONS:** An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS): Thrombophlebitis. Pulmonary embolism. Coronary thrombosis. Cerebral thrombosis. Cerebral hemorrhage. Hypertension. Gallbladder disease. Liver tumors. Congenital anomalies. There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: Mesenteric thrombosis. Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis. The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug-related Nausea, usually the most common adverse reaction. Vomiting, occurs in approximately 10% or less of patients during the first cycle Other reactions, as a general rule, are seen much less frequently or only occasionally Gastrointestinal symptoms (such as abdominal cramps and bloating). Breakthrough bleeding. Spotting. Change in menstrual flow Dysmenorrhea. Amenorrhea during and after treatment Temporary infertility after discontinuance of treatment. Edema Chloasma or melasma which may persist. Breast changes: tenderness, enlargement, and secretion. Change in weight (increase or decrease). Change in cervical erosion and cervical secretion. Possible diminution in lactation when given immediately postpartum. Cholestatic jaundice. Migraine. Increase in size of uterine leiomyomata. Rash (allergic). Mental depression. Reduced tolerance to carbohydrates. Vaginal candidiasis. Change in corneal curvature (steepening). Intolerance to contact lenses. The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted: Premenstrual-like syndrome. Cataracts. Changes in libido. Chorea. Changes in appetite. Cystitis-like syndrome. Headache. Nervousness. Dizziness. Hirsutism. Loss of scalp hair. Erythema multiforme. Erythema nodosum. Hemorrhagic eruption. Vaginitis. Porphyria. Impaired renal function. (ORTHO-NOVUM 1/50□21 and ORTHO-NOVUM 1/50□28 contain tartrazine. Allergic reactions have been reported with the ingestion of this dye in some patients.) **ACUTE OVERDOSE:** Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

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Thanks from 50-year members honored by 1978 MSMS House of Delegates

The picture of the "old timers" 50-year group was gladly received. Mrs. Altland and I both appreciated being a part of the group and the appropriate ceremony that went with it.

J. K. Altland, MD
Lansing

* * *

Thank you very much for mailing the 50-year award to me. It is very attractive and I shall wear it proudly with the satisfaction that it signified an award from a state society which has done much in promoting progress and good will among my fellow practitioners in the state of Michigan. I'm sorry I could not attend the special awards ceremony in Dearborn where several of my classmates received their awards. Thank you again.

C. W. Perry, MD
Kalamazoo

* * *

I want to thank you and the Michigan State Medical Society for the luncheon and ceremony in Dearborn recently. I also want to thank you for the group picture, which just arrived. You certainly take good care of us.

Norman Westlund, MD
Saginaw

VA scholars program seeks applicants

The Veterans Administration is sponsoring a special program to prepare outstanding individuals to assume leadership roles within the health care system. The program is known as the VA Administrative Scholars Program and is open to all qualified individuals from health and health related professions. Each year five individuals are selected for a two-to-four year scholarship. Financial support will equal present compensation up to the limit of the civil service scale.

The program has been in operation for one year, with five scholars currently in residence. A second class has been selected, and will start in September 1978. Applications are now being solicited for the 1979 program year. *Due date is November 1, 1978.*

Interested physicians may call me at (202) 389-3588.

Sincerely,
Harrison Owen
Executive Director
VA Administrative Scholars Program
VA Department of Medicine and Surgery
Washington, DC 20420

Emergency MDs appreciate results of MSMS study

The Board of Directors of the Michigan Chapter of the American College of Emergency Physicians was pleased with the results tabulated in the article on Michigan medical malpractice claims, published in the May 1978 issue of *Michigan Medicine*. It proves again that we have been right — emergency medicine is not a high risk specialty.

We would like to lodge a mild protest, though, on the text of Tables 7 and 9. The name of the specialty is emergency medicine and not emergency room medicine.

Sincerely,
John H. van de Leuv, MD, CM
President, Michigan Chapter ACEP

Sports/medicine clinic draws participants' praise

Once again, I wish to express my appreciation for the thoughtfulness of you, your staff, and the entire organization in remembering me yesterday at the Conference. The extension of invitations to my wife, son, and daughter-in-law was fantastic.

It has been a pleasure working with MSMS and all the Committee members through the years. We wish to express our thanks in behalf of all the schools in the state, as well as our personal appreciation. Thanks again.

Sincerely,
Allen W. Bush
Executive Director
Michigan High School Athletic Association
1019 Trowbridge Road
East Lansing

* * *

Congratulations on the Sports Medicine Clinic yesterday. It was well planned, informative and a great service to all those in attendance.

It was certainly a fine gesture on your part to think of honoring Al Bush at the conclusion of his talk.

Sincerely,
Vern L. Norris
Associate Director
Michigan High School Athletic Association
1019 Trowbridge Road
East Lansing

Government regulations contribute $24 to cost of average hospital stay

According to a recently-completed Michigan Hospital Association study, government regulations cost hospital patients an average of $24 per hospital stay.

The cost impact of six federal regulations was studied by the MHA survey, using an independent methodology developed by the accounting firm of Arthur Young and Co.

If these figures are extended nationwide, the cost of compliance with the six regulations amounted to an early $800 million in 1977, a government cost passed directly to the hospital patient.

The six areas studied were utilization review, physical plant codes, personnel management, the medical arbitration program, certificate of need, and Medicare-Medicaid reimbursement mechanics.

The hospitals reviewed were Sinai Hospital of Detroit; Lansing General Hospital; Emma L. Bixby Hospital, Battle Creek; Pennock Hospital, Hastings; Hackley Hospital, Muskegon; and McPherson Community Health Center, Howell.

Though the amount of money that could be attributed directly to complying with regulations was substantial, it still represented only a small percentage of the annual operating expenses of the hospitals. The average was only 1.5 percent of annual operating expenses.

The following tables present the pertinent figures:

Cost of Compliance Percentage of annual operating expense

Sinai Hospital of Detroit	.9%
Lansing General Hospital	1.5
Emma L. Bixby Hospital	1.6
Pennock Hospital	2.5
Hackley Hospital	2.8
McPherson Health Center	3.0

HOSPITAL DIRECT COSTS ATTRIBUTABLE TO SIX CATEGORIES OF GOVERNMENT REGULATIONS, FISCAL 1976

Regulation Category	*Pennock*	*Mc-Pherson*	*Emma L. Bixby**	*Lansing General*	*Hackley**	*Sinai**	*Category Totals*
Utilization Review	$31,750	$ 88,810	$ 70,973	$ 42,733	$108,369	$218,344	$ 560,979
Plant Codes	7,842	43,646	12,833	10,850	61,730	84,515	212,416
Personnel Management	23,811	2,884	23,100	36,594	19,804	67,900	174,093
Medical Arbitration	8,825	11,243	10,412	24,450	25,807	9,113	89,850
Certificate of Need	7,380	1,749	3,136	9,574	135,865	14,033	171,737
Reimbursement Mechanics	19,196	32,011	28,505	42,882	48,077	117,832	288,503
HOSPITAL TOTALS	$98,804	$171,343	$148,959	$167,083	$399,652	$511,737	$1,497,578

**Fiscal 1977 data*

HOSPITAL DIRECT COSTS ATTRIBUTABLE TO GOVERNMENT REGULATION, PER PATIENT DAY

Regulation Category	*Emma L. Bixby*	*Lansing General*	*Sinai*	*Hackley*	*Pennock*	*Mc-Pherson*	*Average Cost Per Patient Day*
Utilization Review	$1.09	$ .60	$1.04	$1.06	$1.37	$2.99	$1.12
Plant Codes	.20	.15	.40	.60	.34	1.17	.42
Personnel Management	.35	.51	.32	.19	1.03	.10	.35
Medical Arbitration	.16	.34	.04	.25	.38	.38	.18
Certificate of Need	.05	.13	.07	1.33	.32	.06	.34
Reimbursement Mechanics	.44	.60	.56	.47	.82	1.08	.57
HOSPITAL TOTALS	$2.29	$2.33	$2.43	$3.90	$4.26	$5.78	$2.98

Meetings

Calendar for AMA, MSMS, auxiliary and medical assistants

(See also listing of Category I programs on page 444)

Sept. 13 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 26-27 — Auxiliary District Meeting, Mt. Pleasant, contact: Helen Schulte, MSMS headquarters.

Oct. 18-19 — Auxiliary District Meeting, Marshall, contact: Helen Schulte, MSMS headquarters.

Nov. 1 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 7-9 — MSMS Annual Scientific Meeting, Detroit Plaza Hotel, contact: Herb Auer, MSMS headquarters.

Dec. 2-6 — AMA House of Delegates Interim Meeting, Chicago.

Dec. 7 — AMA Winter Scientific Meeting, Las Vegas.

Dec. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Feb. 3-4 — Medical Assistants Midwinter Seminar, Jackson, contact: Helen Schulte, MSMS headquarters.

Social Services reorganizes

The Michigan Department of Social Services recently was reorganized to realign and consolidate its responsibilities and to provide improved service to those using its programs.

As part of the department's reorganization, the Medical Services Administration (MSA) was established. Paul M. Allen has been appointed deputy director of the Department of Social Services for Medical Services Administration.

MSA includes all functions and responsibilities of the Bureau of Medical Assistance. Coincident with the establishment of MSA, duties and responsibilities of the Divisions of Health Services Review, and Authorization and Claims Resolution of the Bureau of Health Care Administration, Michigan Department of Public Health, were transferred to the Department of Social Services and will now be a part of MSA. (Please note, however, that responsibility for medical review and nursing evaluation of patients in long-term care facilities will remain with the Department of Public Health.)

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Deaths

William S. Bowden, MD
Marine City

William S. Bowden, MD, Marine City, has died at the age of 60. Chief of staff at River District Hospital and one of its founders, Doctor Bowden was a graduate of the University of Michigan Medical School, and served in the U.S. Army Medical Corps in World War II. Doctor Bowden was a deputy medical examiner for St. Clair County and was a past president of the St. Clair County Medical Society. He also was a member of the American Academy of Family Practitioners and was a current member of the River District Hospital's board of directors.

Robert T. Burns, MD
Detroit

Robert T. Burns, MD, Detroit, died June 21 at 71 years. A graduate of Wayne State University School of Medicine, Doctor Burns was an obstetrician and gynecologist. He was on the staffs of St. Johns and Grace hospitals, Detroit. He was a member of the Michigan State Society of Obstetricians and Gynecologists and was a fellow in the American College of Obstetricians and Gynecologists.

Harold G. DeVries, MD
Holland

Harold G. DeVries, Holland, 73, died April 26. A specialist in ophthalmology, Doctor DeVries was a graduate of the University of Michigan Medical School and was affiliated with Holland and Zeeland city hospitals. He was a fellow of the American Academy of Ophthalmology and Otolaryngology and a member of the Southwestern Michigan Triological Society.

Ernest D. Gardner, MD
California

Ernest D. Gardner, MD, 63, former dean of the Wayne State University School of Medicine, died Feb. 21. He had been serving as a professor of neurology, orthopedic surgery and human anatomy at the University of California at Davis. Doctor Gardner joined WSU as an assistant professor of anatomy, was later promoted to professor, chairman of anatomy, associate dean and then dean. Doctor Gardner left Wayne State to accept a position as visiting professor of anatomy at the University of California at Davis. Before coming to WSU, Doctor Gardner held positions at the University of Washington, Stanford University, Washington University School of Medicine (St. Louis) and the University of Southern California. Doctor Gardner received his MD degree from the School of Medicine at Stanford University. He gained national recognition in medical education for his contributions to professional literature. Doctor Gardner served on several national boards and commissions involved in medical practice and medical education in the nation, including the United States Public Health Service — Division of Physician Manpower, and the Neurology Study Section of the National Institutes of Health.

Hassan Ghandchi, MD
Birmingham

Hassan Ghandchi, MD, Detroit area surgeon, died June 8 at the age of 43. Doctor Ghandchi graduated from the University of Teheran Medical School, Teheran, Iran. A specialist in hand surgery, he was on the staffs at St. Mary's Hospital, Livonia and Mt. Carmel Mercy Hospital.

Lyle E. Heavner, MD
Grosse Pointe Woods

Lyle E. Heavner, MD, Grosse Pointe physician, died June 6 at the age of 73. Doctor Heavner graduated from Wayne State University School of Medicine and was on the staffs of Alexander Blain, Bon Secours and Cottage hospitals. A specialist in internal medicine, he was a member of the Detroit Gastroenterological Association as well as the American College of Gastroenterology.

William D. Knapp, MD
Flint

William D. Knapp, MD, 64, died May 30. A Flint eye specialist, Doctor Knapp graduated from the University of Michigan Medical School. He served as a flight surgeon during WW II. His memberships included the American Association of Ophthalmology, the Flint Academy of Surgeons, the Michigan Tri-City EENT Society, and the Michigan Ophthalmology Society.

Robert W. Parr, MD
Dunedin, FL

Robert W. Parr, MD, Dunedin, FL, died May 6 at the age of 84. A graduate of the Johns Hopkins University School of Medicine, Maryland, Doctor Parr was affiliated with Woman's Hospital and Henry Ford Hospital. He was a member of the FACS.

Theophile Raphael, MD
Atlanta, GA

Theophile Raphael, MD, Atlanta, Georgia, died April 29 at 86. A psychiatrist, he was a graduate of the University of Michigan Medical School and served at the University of Michigan Student Health Service. Doctor Raphael was a member of the American Psychiatric Association and the American Neurological Association.

Harold F. Raynor, MD
Clarkston

Harold F. Raynor, MD, Detroit area physician, died June 7 at the age of 86. Doctor Raynor graduated from Wayne State University School of Medicine. He was a physician for the Detroit Fire Department and Old Providence Hospital, as well as an honorary physician for the Highland Park police and fire departments. He was a member of the American Academy of General Practice, of which he was a past secretary.

Robert H. Willard, MD
Flint

Robert H. Willard, MD, Flint anesthesiologist, died June 17 at age 56. He graduated from the University of Nebraska College of Medicine and was affiliated with McLaren General, Hurley, and St. Joseph's hospitals, Flint. Doctor Willard was a member of the Michigan Society of Anesthesiologists and the American Society of Anesthesiologists.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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RESIDENT OR PART-TIME PHYSICIAN for Saturday at Family Clinic. Call or write — Trail Clinics, P.C., Cindy Papuga, Clinic Secretary, 313/861-4400, 18254 Livernois, Detroit, MI 48221.

GLADWIN: Opportunity to lease well-equipped office, including X-ray and laboratory, in this rapid growing Central Michigan community. A 45-bed hospital is available as well as excellent schools and churches of your choice. Contact: Joan A. Howarth, Gladwin Clinic, P.C., 103 N. Bowery, Gladwin, MI 48624, Phone: 517/426-9275.

FAMILY PRACTICE — established solo practice in town of 6,000, service area 18,000; located in Northern Lower Michigan; new full service 129-bed hospital; close referral center. This area offers the full range of water sports, large and small game hunting, snow skiing, etc. Contact: David M. Coates, President, Community Memorial Hospital, Cheboygan, MI 49721, Phone: 616/627-5601.

GENERAL INTERNIST, BOARD ELIGIBLE to join with established general internist, private practice. Salary leading to partnership. Northern Oakland Co. Area. Reply to P.O. Box 3276, Pontiac, MI 48059.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park, there are openings for physicians board qualified as internists, family physicians or psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently over forty thousand per year, plus fringe benefits, including life, accident, long term disability, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7789.

ORTHOPEDIC SURGEON — Board certified/eligible orthopedic surgeon needed by well-established, 42-physician multi-specialty group in Northwest Ohio. Major regional medical center with large referral base. Staff includes four rheumatologists. Top salary, excellent fringe benefit program along with all corporate benefits. Please forward current curriculum vitae and salary requirements to Box 11, MSMS, 120 W. Saginaw, East Lansing, 48823.

THE CHILDREN'S LEUKEMIA FOUNDATION of Michigan (a United Way Agency) is interested in funding research in the general field of hematology (adults and children). The official grant proposal form must be used. The deadline for submission of requests is October 13, 1978. Questions regarding the above should be directed to: Arnold R. Axelrod, Chairman, Medical Advisory Board, Children's Leukemia Foundation of Michigan, Department of Medicine, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit, MI.

MICHIGAN — Active well-established large general practice, general surgery, in desirable recreational area, Northern Michigan. Excellent gross, modern equipment. Clinic bldg. with or without adjoining beautiful large home with lighted tennis court and swimming pool. Will lease or sell one or both. Favorable terms. Contact N. Lentini, MD, Lentini Medical Clinic, PC, 401 Elm Street, Cheboygan, MI 49721, 616/627-5656.

FAMILY PRACTITIONERS, INTERNISTS, and/or OB-GYNs needed in growing, prosperous Dutch community to join a Board Certified family physician in existing practice, or solo available. Excellent economy with medical education, recreational lakes, and ski resorts within 20 mile radius. Will help solo practice to start out. Guarantee net income of $40,000 for first year partner. Call Grand Rapids, MI, 616/531-9803 between 9 and 11 p.m.

Miscellaneous

RELAX with a day or more of grouse and woodcock hunting in the beautiful autumn woods of Northern lower Michigan. My dogs and I will guide you personally. For dates and prices or more information call "Autumn Memories Kennels," Dale E. Dumaw, DVM, Reed City, MI 49677. 616/832-5597.

USED OFFICE EQUIPMENT FOR SALE — Michigan League for Human Services, 200 Mill Street, Lansing, MI 48933. *Addressing Machine** — Desk top Scriptomatic #38, automatic addressing machine. Up to 2,500 addresses per hour using inexpensive cards. Ten years old. $300 or best offer. *Offset Press** — 1250W Multilith-Multigraph Offset machine with chute delivery, chrome cylinders, auxiliary ink attachment, and light. Eleven years old. $1,800 or best offer. Call Herbert Yamanishi, 517/487-5436. *Must provide own shipping or hauling.

CAPE COD: FALMOUTH. For sale. Beautiful townhouse condominium. Ideal for investment or year-round retreat. Only two years old. Two bedrooms, modern kitchen, 1½ baths, woodburning fireplace in large living room with dining area, sliders to patio. Only 41 units on 25 heavily wooded acres. Swimming pool, tennis court. Near ocean beaches, shopping, golf. Contact Harold Bach, R.E. 617/540-0707.

PROFESSIONAL OFFICE FOR LEASE — Prime location in Grandville, a prosperous Dutch community near Grand Rapids. 2725 square feet for group of three doctors. Office can be divided to suit interested party's needs. Call 616/457-2450 between 9 and 5 p.m. or 616/531-9803 from 9 to 11 p.m.

FOR SALE — MPMLC surplus certificate. Basic value $1000. Please call from 1-6 p.m. Monday through Thursday. Phone 313/852-4100.

FOR SALE — 320 Acres — Excellent deer and pat hunting. Located S.W. of Alpena on four county lines — N.E. corner of Oscoda Co. bordered by Alpena, Montmorency and Alcona Cos. The Turtle Lake Club is our neighbor to the north and west. Three buildings — Main sleeping cabin — fireplace and gas propane heat, 1½ car garage. Week days call Bill or Jack, 313/644-0100.

GROUP PRACTICE NEEDED — all new medical center in prime location of Brighton. 2000 square feet office unit, includes four exam rooms or more, private office and entrance, laboratory, excellent parking, ideal to accomodate one or two doctors. Immediate occupancy. Call Davis Professional Bldg., 313/229-2752.

JAMES MARQUETTE

Plan a Mini-Vacation, And Earn Category I Credits

MSMS will offer five half-day Category I courses on Saturday and Sunday September 23-24 at the Northern Michigan University campus.

The practical courses will be:
- What's New in Pharmacology?
- Dermatology for Non-Dermatologists
- Frequent Problems in Allergy
- Billary Tract Disease
- Neurology

Costs: $10.00 per credit hour. Each course will be for 3 hours or $30 to cover the costs.

Rooms are available at Marquette Holiday Inn.

For details, write to:

MSMS CME Programming Committee
120 West Saginaw
East Lansing 48823
Phone: 517/337-1351

Visit Marquette and Upper Peninsula This Fall. Take a Break from the Office Routine.

Those committed to national health system have conflict of interest on planning boards

The assertion is frequently made that individuals who are active in health care delivery or policy making should have no place on the boards of groups paying for health care or planning it, as there inevitably is a conflict of interest. I don't support this thesis, since, in my experience, what these individuals bring to discussions in first-hand knowledge of the health care system far exceeds what the sociologist, the administrator, or the health planner brings.

However, if for the sake of argument we grant the thesis, can't a case be made that those who come from specific organizations with a pre-determined policy present a comparable conflict of interest and should accordingly be barred from such activities?

I have in mind specifically an article written by Dolly Katz, Medical Writer of the *Detroit Free Press* and published June 15, 1978. To Quote:

> "The UAW, for example, whose members account for a third of the Blues' 5.4 million subscribers, supports public financing of health care and is working to get a national health insurance bill through Congress.
>
> " 'I don't quarrel with any organization if they want to put money together for political purposes to enhance their ideals,' said Arthur Hughes, a UAW official on the Blues 47 member board. 'But when those ideals go contrary to those programs that the UAW has (negotiated), then there is a conflict in our relationship. I think there's a direct challenge.' "

Mr. Hughes is employed as administrative assistant to the vice president, Chrysler Department, UAW, a member of the board of Blue Cross/Blue Shield of Michigan as a consumer-labor representative, and is currently chairman of the Consumer Relations Committee of BCBSM. If he reflects the thinking of the UAW, and I find it to be a doctrinaire organization in which no one in a position of responsibility speaks outside established policy, then there is a real conflict of interest in any of the UAW hierarchy who sit on public boards.

The quote indicates Mr. Hughes does not know where the UAW ends and other organizations begin. He, as a Board member, has fiduciary responsibilities to BCBSM. He seems to find it an extension of the UAW, and expects that only UAW policies will prevail. He does not seem to know how to function in a democratic setting, how to abide by policy established by a majority of an organization, or how to work for modification of that policy.

Louis E. Heideman, MD
MSMS president

There must inevitably be conflict and differences of opinion between the UAW and BCBSM, a private, not-for-profit corporation, given the UAW commitment to a national health system. The UAW's plans, and their actions would seem to confirm this, suggest BCBSM will be taken over by the government, an action not particularly desired by the corporation or a majority of the BCBSM board and of the corporate members. Given this fundamental conflict and a UAW effort to permit only what will further its goals, isn't there a very real conflict of interest?

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

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Her next attack of cystitis may require

the Bactrim™ 3-system counterattack

ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resi tant organisms. Thus, Bactrim reduces the risk of introit colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine Medigram

VOL. 77, NO. 24 AUGUST 28, 1978

APSULES

SMS PRESIDENT LOUIS E. HEIDE-
AN, MD, muses, for the sake
f argument, that conflict of
nterest can be charged in the
ase of those who come from
pecific organizations with
re-determined policy and sit
n health planning boards.
re of his discussion can be
und on page 472 of the August
ssue of Michigan Medicine.

* * *

ATES FOR THE 1979 MSMS HOUSE
F DELEGATES are May 4-6. The
nnual meeting will be held at
he Kalamazoo Hilton. Further
etails are available from
ichard Campau, at MSMS.

* * *

ULL DETAILS ABOUT COURSES AND
EGISTRATION for the 1978 MSMS
nnual Scientific Meeting will
ppear in the next issue of
edigram and the September
ichigan Medicine.

* * *

HE AMA JUDICIAL COUNCIL has
uled it is not improper to
ive patients a discount or
ebate if they pay bills on
ime, or to charge them an
xtra amount if they must be
ebilled, as long as these
iscounts or charges reflect
service charge for the ad-
inistrative cost actually
nvolved in rebilling. The
atient must be notified in
dvance of this practice. In
ddition, The Council says
hysicians should note the
iscounts, rebates and billing
harges make it difficult to
etermine usual and customary
harges for third party payors.

MSMS advises physicians on second opinion programs

Michigan physicians currently are being asked to participate in two second surgical opinion studies sponsored by Medicare and the Prudential Insurance Company. MSMS has not been asked to endorse either of these programs. The Council has given its endorsement to only one program, which it felt met the criteria stated in House resolution 76A-33 requiring physician input into the design of a program to insure scientific validity and free choice of physicians. Unfortunately, this program, developed by the University of Michigan Health Services Research Center, did not receive funding from the government.

MSMS feels when there is a question as to the choice of treatment, patients should be offered a second surgical opinion. However, the decision to participate in a second surgical opinion program must remain with individual physicians and patients. Committees of physicians have worked extensively with many organizations regarding this matter, but in our opinion, none of the present programs meets MSMS House criteria.

Additionally, MSMS is concerned that various reimbursement features of these programs could result in financial penalties to the patient if he/she chooses not to participate in the programs. Therefore, the patient may be confused about the choice of treatment and attending surgeon, which may lead to a delay in receiving needed care.

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SEP 13 1978

Two special forms in this issue for you . . .
Page 2 — Registration form for CME weekend
Page 4 — Questionnaire asking ideas for new projects

JAMES MARQUETTE

Earn CME credits, visit UP in the fal

MSMS members from across the state are invited to take a mini-vacation and preview autumn while earning some CME credits in Marquette, Sept. 23-24. Six courses offering three Category I credits each will be presented on allergy, neurology, renal failure, new drugs, athletic medicine and biliary tract diseases. The courses will be jointly sponsored by MSMS and the Michigan Academy of Family Practice on the campus of Northern Michigan University.

Carl F. Hammerstrom, MD, Marquette, chairman of the MSMS Committee on CME Programming which is planning the program, invites physicians and their families to take a weekend vacation trip to "tour our fall color and the natural scenic beauty of our area while earning some CME credits."

Lodging reservations should be made directly with local Marquette hotels and motels. Use the form below to register for courses or to inquire about the program.

1978 MICHIGAN UPPER PENINSULA REGIONAL C.M.E. CONFERENCE
Northern Michigan University, Marquette
Saturday-Sunday, September 23-24

ADVANCE REGISTRATION FORM

Name (please print) ______________________________

Address ______________________ City ____________ Zip ______

I'd like to enroll in the following courses AND receive the detailed information on the Conference as soon as it is printed: *(Choice of one for each time slot.)*

Saturday Morning -- 9:00 a.m. to 12:15 p.m.
($30) ____ Renal Failure, Director: Gilbert Mayor, MD, MSU
($30) ____ Neurological Problems, Director: Janice Lindstrom, MD, Marquette

Saturday Afternoon -- 1:00 to 4:15 p.m.
($30) ____ Biliary Tract Disease, Director: Daniel English, MD, MSU
($30) ____ Allergic Problems, Director: John Anderson, MD, Henry Ford Hospital

TOTAL AMOUNT DUE FOR COURSE(S) AND/OR LUNCHEON (multiply number of courses by $30, add $5 for lunch if applicable) $________ *(Advance payment requested)*

Sunday Morning -- 9:00 a.m. to 12:15 p.m.
($30) ____ New Drugs, Director: George Royer MD, Upjohn Company
($30) ____ Athletic Injuries, Director: Roy Bergman, MD, Escanaba

Luncheon will be served on Saturday noon. If you wish to make a reservation, please indicat here: ____

Please make check payable to MSMS and mail with this registration form to:

MSMS Upper Peninsula Regional Conference
Box 950
East Lansing, MI 48823

☐ I'm thinking about attending this Conference. Would you please send me detailed information as soon as it is printed.

PSULES/continued

NEW, REVISED VERSION of the
SMS Constitution and Bylaws
s in print. Interested MSMS
embers may obtain copies by
ontacting Mrs. Davis at MSMS
eadquarters, 517/337-1351.
opies already have been dis-
ributed to component society
ecretaries, presidents,
xecutive secretaries, and to
SMS delegates and councilors.

* * *

OCTOR COURY NAMED--John J.
oury, MD, Port Huron, AMA
rustee and past MSMS presi-
ent, has been named vice
resident of the AMA Education-
l Research Fund (AMA-ERF) and
ember of the AMA Ad Hoc Com-
ittee to revise the AMA's
rinciples of Medical Ethics.

* * *

N ALL-DAY SYMPOSIUM on Re-
earch on Mental Health is
lanned Sept. 8 at MSU's
ellogg Center. Sponsors are
he Mental Health Association
n Michigan, Michigan Dept. of
ental Health, and departments
f psychiatry at the three
edical schools. Six hours of
ategory I credit will be
warded. Further information
s available from the MSU
ffice of Continuing Education.

* * *

HYSICIANS INTERESTED IN
TUDYING ways to improve the
are of the elderly through
etter continuing medical
ducation programs in Michi-
an are invited to write MSMS
nd volunteer for a new task
orce. Please write MSMS Com-
ittee for CME Programming,
20 W. Saginaw St., P.O. Box
50, East Lansing 48823.

Progress continues on developing cost-effective BCBSM program

"Much progress" is being made on developing a cost effective Blue Cross/Blue Shield of Michigan service benefit program, as reported by Donald K. Crandall, MD, Muskegon. Physician-Blues liaison group met for the fourth time Aug. 22, in talks at BCBSM headquarters. "We are working through the four principles of the statement adopted in May by the MSMS House of Delegates and the Blues' board," says Doctor Crandall. "There are a few problem areas which have to be resolved, but we anticipate we will make our January 1 target date for completion of work."

Copies available to physicians of preliminary State Health Plan

Copies of the 460-page Preliminary State Health Plan are available to interested physicians if they will write the Office of Health and Medical Affairs, Department of Management and Budget, State of Michigan. The proposed document is being distributed to HSAs and other health organizations this month and is being made available for public review and comment, including that of physicians. The state health plan, once approved by the governor and the legislature, "shall serve as the principle guide for the development of state health programs and for the allocation of resources to health activities in the state." The SHP's role is one of the most important principles of the new PA 323 of 1978, the State Health Planning and Resources Development Act.

Michigan Medicine high in national ads

Did you know? *Michigan Medicine* stands fifth among state medical journals for the total number of national advertising pages carried in issues this year. The MSMS medical news magazine is averaging 24 pages each month of national advertising, trailing *Texas Medicine* only slightly. The Texas journal averages 26 pages.

Autos, UAW forming own HMO

The Big Three auto companies and the UAW are forming their own HMO, to be based at Henry Ford Hospital. The HMO will be offered to all Big Three employees and to the general public and hopes to attract 100,000 subscribers. The HMO, still in the planning stages, may be in operation by Jan. 1, 1979.

Suggestions needed for projects to help MDs provide more effective service

The Michigan Foundation for Medical and Health Education is seeking projects to augment and support on-going programs of Michigan State Medical Society. They should present activities of doctors in ways which will result in improved understanding and reflect positively upon Michigan doctors.

Several ideas submitted to the Foundation are listed in the adjoining column. You are asked to send your reaction to these suggestions...and to submit any ideas you have in the space below or on additional paper.

My suggestion is:

____
____
____
____
____
____
____
____
____
____
____
____
____

Your reaction important:

Please fill in and return this form on MD programs

How do you rate these ideas?

Great Value	Some Value	Little Value	
Check			
			Physicians need help dealing with the non-professional majorities serving on eight Health System Agencies. The Foundation should finance appearance of experts at hearings to help produce wisest recommendations.
			Sponsor programs with media people to help reporters understand economic topics and dynamics of new health care systems.
			Present pertinent facts of socio-economic aspects of health care for distribution by local electronic media. Each tape will deal with a specific problem of importance
			Set up workshops to determine the roles of emerging ancillary professions -- physician's assistants, paramedics and emergenc technicians -- in the current field of medicine.

Please send to Harry A. Towsley, MD, President, MFMHE, Box 950, East Lansing 48823.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

Vol. 77 No. 24, August 28, 1978

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Managing Editor: Judith Marr

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If your address changes, please mail the label above to MSMS headquarters with your new address.

Here is your Program for . . . MSMS Scientific Meeting, Nov. 7-8-9 At Detroit Plaza . . . Register Today!

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SEP 26 1978

USE REGISTRATION FORM ON PAGE 19

Michigan Medicine
Medigram

VOL. 77, NO. 25 SEPTEMBER 11, 1978

MSMS members are urged to egister now for the fifty-seven half-ay Category I credit courses to e offered November 7-8-9 at the ISMS Annual Scientific Meeting t the spacious Detroit Plaza in the etroit Renaissance Center.

In this issue are course descrip- ons and information about the ponsors, course directors, in- ructors, along with a registration rm on page 19.

“Once again the courses will cus on practical advances in pa- ent management and will stress he practical aspects of everyday atient care,” points out Robert F. Wilson, MD, of Detroit, again hairman of the Annual Scientific Meeting.

arly registrations urged

“We encourage early advance egistration because some of the ourses will be filled quickly when he enrollments reach the maxi- mum for the rooms which are dif- erent sizes at the Plaza,” stresses arl F. Hammerstrom, MD, chair- an of the MSMS Committee for ME Programming.

Physicians will be able to select x half-day courses and to earn 18 ours of Category I CME credit at he three-day meeting. Credits will ount toward the Michigan Medi- al Practice Board requirements or relicensure and the AMA Physicians Recognition Award. Many of the courses will provide rescribed credits required by the merican Academy of Family hysicians.

Many of the Michigan medical pecialty societies and the three Michigan medical schools worked losely with Doctor Wilson to de- elop half-day courses. “Coopera- on has been excellent again,” eclares Doctor Wilson. “We had ar more proposals for courses han we could proceed with be- ause the number of rooms availa- le was limited,” he adds.

Noted speakers coming

Many of the courses will spotlight out-of-Michigan medical authorities who have been invited by the course directors. All the courses will utilize the highly-recognized Michigan leaders in the many specialty fields.

The inside back page of this issue contains the registration blank. When the forms and checks are received at MSMS, MSMS will reserve a place for the physician in the courses selected. MSMS will acknowledge receipt of the advance registration.

Room registrations are to be made direct by the physician. Physicians may write to the Detroit Plaza, Renaissance Center, Detroit, 48243, to reserve a room for the nights desired. “Be sure to mention that you will be attending the MSMS Scientific Meeting in the letter and you will be given a special discount,” reports Doctor Hammerstrom.

The Detroit Plaza will provide a luncheon in the MSMS Exhibition Hall each noon. The registration form asks physicians to indicate which days they would like to take advantage of this special arrangement.

Tuition fees nominal

The tuition of $4 per credit hour for MSMS members or $8 per hour for non-MSMS members will help cover the MSMS expenses for the Scientific Meeting. MSMS has a policy that funds from MSMS dues should cover the salaries involved in putting on the project, but the tuition charge should cover the cash payment for speakers’ honoraria and travel, printed programs, audio visual services, coffee breaks, printed materials, etc.

Residents and interns will be permitted to register in advance without charge.

The September issue of *Michigan Medicine* carries considerable information about the Scientific Meeting. There are articles about the Detroit Plaza, about special non-medical events during the same week, about the course directors, etc.

Phone MSMS if questions

Any physician with questions may phone MSMS and ask for Herb Auer or Sherry Fent at 517/337-1351.

Doctor Hammerstrom, in reviewing the extensive Scientific Meeting programs praises the work of Doctor Wilson. Doctor Wilson, assistant dean at Wayne State University College of Medicine, is serving his third year as the chairman.

The first planning meeting for this 1978 meeting was held in October of 1977 when representatives of specialty societies were invited to submit ideas for 1978 courses. Several similar meetings were held during the year, with progress reports at each meeting of the MSMS Committee for CME Programming.

FILL IN REGISTRATION FORM ON PAGE 19, MAIL TO MSMS

Courses Tuesday Morning, Nov. 7

ALL COURSES RUN FROM 8:30 TO NOON WITH HALF-HOUR BREAK

☐ Basic Cardiac Life Support

PRESENTED BY: The Annual Scientific Meeting Committee and Michigan Heart Association

This course will consist of 1 hour of didactic teaching in a lecture-seminar fashion, followed by 2 hours of practical individual instruction on manikins. Special emphasis will be made on external cardiac massage, management of the airway, and ventilation.

COURSE DIRECTOR: Daniel T. Anbe, MD, Detroit

☐ Common Pitfalls in the Management of Malignancies

PRESENTED BY: Department of Oncology, Wayne State University School of Medicine

This course will assist primary physicians and general surgeons in avoiding common mistakes in the management of cancer. Through case presentations of mishandled cases, principles of adequate staging, selection of treatment modalities and diagnosis of commonly-missed complications of cancer and its therapy will be brought out.

COURSE DIRECTOR: Vainutis K. Vaitkevicius, MD, Detroit

PRESIDING: Doctor Vaitkevicius

SPEAKERS:

Vainutis K. Vaitkevicius, MD, Professor and Chairman, Department of Oncology, Wayne State University School of Medicine

Thomas Buroker, DO, Associate Professor, Department of Oncology, Wayne State University School of Medicine

Amnuay Singhakowinta, MD, Associate Professor, Department of Oncology, Wayne State University School of Medicine

Bohumil A. Samal, MD, Associate Professor, Department of Oncology, Wayne State University School of Medicine

☐ It's Now Easy to Recognize and Manage Chronic Obstructive Pulmonary Disease

PRESENTED BY: Pulmonary Division, University of Michigan Medical School; Michigan Thoracic Society and Michigan Chapter, American College of Chest Physicians

This session will provide primary care physicians with practical information on the recognition, diagnosis and management of chronic obstructive pulmonary disease. Guidelines will be given for rational therapy of the outpatient, including criteria for the use of home oxygen therapy. At the end of the course, the physician will be able to describe causes of air flow limitation, to list criteria for early recognition, to list rational modes of therapy and to describe a practical rehabilitation program. A brief pre and post-test will be given.

COURSE DIRECTOR: John G. Weg, MD, Ann Arbor

PRESIDING: Doctor Weg

SPEAKERS/SUBJECTS:

John G. Weg, MD, Professor of Internal Medicine a
Physician-In-Charge, Pulmonary Division, University
Michigan Medical School
"The Pathophysiology of Chronic Air Flow Limitati
— The Basics"

Thomas L. Petty, MD, Professor of Medicine and Hea
Division of Pulmonary Sciences, University of Colora
School of Medicine, Denver
"Earlier Recognition"

Paul A. Kvale, MD, Physician-In-Charge, Pulmonary Div
sion, Henry Ford Hospital and Clinical Assistant Profess
of Internal Medicine, University of Michigan Medic
School
"Sensible Out-Patient Care, Including O_2"

David R. Dantzker, MD, Assistant Professor of Medicin
Pulmonary Division, University of Michigan Medic
School
"Treatment of the Acute Episode"

Edward H. Chester, MD, Associate Professor of Medicin
Case-Western Reserve School of Medicine and Chie
Pulmonary Division, VA Hospital, Cleveland
"Practical Rehabilitation"

☐ Management of Diabetes Mellitus: Problems i Acute and Chronic Care

PRESENTED BY: Michigan Diabetes Research and Trai
ing Center

This course is designed for general or specialty practic
physicians and other health care professionals to discus
current concepts in the management of diabetes mellitu
Emphasis will be placed on the importance of control
diabetes in the prevention of complications of the disease
and on the multi-disciplinary team approach to the care
the diabetic patient. Upon completion of this course, th
health care professionals will be able to make any neces
sary modifications in their approach to treatment in orde
to improve control of the disease, and to develop multi
disciplinary health care teams in their communities.

COURSE DIRECTOR: Sumer Pek, MD, Ann Arbor

PRESIDING: Doctor Pek

SPEAKERS/SUBJECTS:

Sumer Pek, MD, Associate Professor of Internal Medicine
University of Michigan Medical School, Division of En
docrinology and Metabolism, Ann Arbor
"Definition and Improved Control of Diabetes"

Saul Genuth, MD, Professor of Medicine, Case-Wester
Reserve University; Director, Saltzman Institute for Clini
cal Investigation, Cleveland
"Management of Diabetic Ketoacidosis and Hyperosmo
larity"

Robert N. Frank, MD, Associate Professor of Ophthalmology, Kresge Eye Institute, Wayne State University School of Medicine, Detroit
"Management of Eye Problems of the Diabetic Patient"
Jacques F. Roux, MD, Professor of Obstetrics and Gynecology, Michigan State University College of Human Medicine, East Lansing
"Management of the Pregnant Diabetic and Her Fetus"

PANEL: "Multi-Disciplinary Approach to Care of Diabetic Patients" **Martha L. Spencer, MD,** Assistant Professor of Pediatrics, University of Michigan Medical School, Ann Arbor; **Charles R. Rettig, DPM,** Staff Podiatrist, Chelsea Community Hospital, Chelsea; **Linda Strodtman, RN, MS,** Clinical Nurse Specialist, University of Michigan Medical School; **Norma Grills, RD, MS,** Department of Dietetics, University Hospital and **Merle Foss, PhD,** Associate Professor, Department of Physical Education, University of Michigan, Ann Arbor.

☐ Newer Developments in the Evaluation and Treatment of the Hypertensive Patient

PRESENTED BY: Department of Internal Medicine, Wayne State University School of Medicine

This course will present guidelines to the practicing physician on the levels of blood pressure, history, physical examination, and laboratory tests required to diagnose hypertension. Drug and other therapies will also be discussed, as will such special problems in hypertension such as enal failure, hemolytic uremic syndrome and the pre and post-operative patient.

This course is supported in part by a financial grant from Boehringer-Ingelheim Ltd.

COURSE DIRECTOR: Charles P. Lucas, MD, Detroit

PRESIDING: Doctor Lucas

SPEAKERS/SUBJECTS:

Charles P. Lucas, MD, Professor of Internal Medicine, Wayne State University School of Medicine
"Diagnosis of Hypertension and the Workup of the Hypertensive Patient"
Andrew Zweifler, MD, Professor of Internal Medicine, University of Michigan Medical School
"Current Therapy of Essential Hypertension"
Robert G. Luke, MD, Professor of Internal Medicine, University of Kentucky Medical Center, Lexington
"Special Problems in Hypertension: In Pregnancy, In Hemolytic Uremic Syndrome, In Chronic Renal Failure and In Pre and Post-Operative State"

☐ Sex and The Heart Patient

PRESENTED BY: Department of Obstetrics and Gynecology, Wayne State University School of Medicine

The course will offer a broad overview of sexual functioning. It will also deal with specific sexual issues referrable to cardiac problems: i.e. hypertension and myocardial infarction, etc.

There will be an audio-visual presentation and ample time for questions and answers.

COURSE DIRECTOR: Mario A. Petrini, MD, Detroit

PRESIDING: Doctor Petrini

SPEAKERS/SUBJECTS:

Anthony Petrilli, MD, Wayne State University Department of Psychiatry
"Sex and the Heart Patient"

☐ What's New and Practical in Peripheral Vascular Surgery

PRESENTED BY: Department of Surgery, University of Michigan Medical School

New techniques regarding diagnosis and treatment of peripheral vascular disorders will be described. Specific emphasis will be placed on current assessments of the efficacy of certain procedures new to the practioner's armamentarium. Examples include: non-invasive tests of vascular insufficiency, use of diagnostic ultrasound, role of renin determinations in evaluating hypertension and use of expanded teflon grafts for distal arterial reconstructions.

COURSE DIRECTOR: James C. Stanley, MD, Ann Arbor

PRESIDING: Doctor Stanley

SPEAKERS/SUBJECTS:

S. Martin Lindenauer, MD, Professor of Surgery, University of Michigan Medical School and Director, Diagnostic Vascular Clinic, University Hospital
"Non-invasive Assessment of Extremity Vascular Disease"
"Femoral-Popliteal-Tibial Arterial Reconstructions"
James C. Stanley, MD, Associate Professor of Surgery, University of Michigan Medical School, and Head, Peripheral Vascular Surgery Service, University Hospital
"New Techniques in Aortic Reconstructive Surgery"
"Surgical Intervention for Renovascular Hypertension"
Errol E.Erlandson, MD, Assistant Professor of Surgery, University of Michigan Medical School and Director, Surgical Intensive Care Unit, University Hospital
"Diagnosis and Treatment of Extremity Vasospastic Disease"
"Extracranial Carotid Artery Occlusive and Aneurysmal Disease"

Courses Tuesday Afternoon, Nov. 7

ALL COURSES RUN FROM 1:30 TO 5:00 WITH HALF-HOUR BREAK

☐ Alcohol and Medical Practice

PRESENTED BY: MSMS Committee to Assist Impaired Physicians

This course will build upon a foundation of demographics to help practicing physicians recognize alcoholism and to help the practicing physician deal effectively in the intervention of alcoholism. Special emphasis will be given to ways to motivate the alcoholic. The course will help the physician with alcoholic problems and also will advise physicians who are responsible for medical ethics and practice quality control involving physicians with alcohol problems.

COURSE DIRECTOR: Russell F. Smith, MD, Brighton

PRESIDING: Doctor Smith

SPEAKERS/SUBJECTS:

James W. West, MD, Assistant Professor, Department of Psychiatry, Rush-Presbyterian-St. Luke's Medical Center, Chicago
"To Our Health, Doctors"

Russell F. Smith, MD, Chairman, MSMS Committee to Assist Impaired Physicians and Medical Director, Brighton Hospital and Guest House Sanitariums
"Recognizing the Problem Drinker"

Michael Liepman, MD, Instructor, Department of Psychiatry, University of Michigan Medical School.
"Intervention and Motivation in Alcoholism"

☐ Assessment and Management of the Patient with Acute and Chronic Renal Failure

PRESENTED BY: Department of Internal Medicine, Nephrology Program, Michigan State University College of Human Medicine

This course will provide basic and applied concepts applicable to the practicing physician in dealing with the diagnosis and management of common problems associated with renal disease. A course participant will learn interpretation of renal function tests, prognosis, treatment and outcome of acute and chronic renal disease in order to help him/her deal more effectively with patients in the office and hospital.

COURSE DIRECTOR: Gilbert H. Mayor, MD, East Lanisng

PRESIDING: Doctor Mayor

SPEAKERS/SUBJECTS:

Gilbert H. Mayor, MD, Associate Professor of Internal Medicine and Surgery, Michigan State University College of Human Medicine
"The Need for Dialysis in the Treatment of Acute Renal Failure."
"Diagnosis and Treatment of Acute Renal Failure"

R. W. Rosenbaum, MD, Assistant Professor, Intern
Medicine, Michigan State University College of Hum
Medicine
"The Use and Interpretation of Renal Function Tests'
"Management of Advanced Diabetic Nephropathy"

William Klein, MD, Director, Office of Health Services a
Professor of Community Health Science and Medicin
Michigan State University College of Human Medicine
"Metabolic Problems in Chronic Renal Failure"

Byron Noordewier, PhD, Instructor, Department
Medicine and Pharmacology, Michigan State Universi
College of Human Medicine
"Pharmacologic Considerations in the Treatment
Acute and Chronic Renal Failure"

Phillip Hofsten, MD, Associate Professor, Renal Divisio
Washington University, Barnes Hospital, St. Louis
"Glomerulonephritis Presenting as Acute Renal Failure
"Clinical Assessment of Proteinuric States"

☐ Care in the September Years

PRESENTED BY: Michigan Academy of Family Phys
cians

This course is designed for the family physician to becon
acquainted with the problems of geriatric patients. Bett
care of the psychological and physical problems of th
geriatric patient will be taught, with emphasis on the fami
physician's responsibility to geriatric patients, treatment
depression and drug use and abuse. There will be both d
dactic lecture and a panel discussion of questions from th
participants.

COURSE DIRECTOR: Edward Cotton, MD, Kalamazoo

PRESIDING: Doctor Cotton

SPEAKERS/SUBJECTS:

Roy J. Gerard, MD, Professor and Chairman, Departmen
of Family Practice, Michigan State University College
Human Medicine
"The Family Physician and His Obligation to the E
derly"

Sister Mary Kroger, PhD, Assistant Professor, Departme
of Community Health Sciences, Michigan State Universit
College of Human Medicine
"Age Changes in a Situational Context"

Charles W. Shipman, MD, Traverse City, Head, Michiga
State Medical Society Task Force on Care of the Elderly
"Use and Abuse of Drugs"

☐ Current Trends in Coronary Artery Bypass Gra Surgery

PRESENTED BY: Division of Cardiology, University
Michigan Medical School

Recent advances in assessment and results of coronary a
tery bypass graft surgery in patients with angina pectori
will be discussed. Particular emphasis will be placed on a
pects of exercise ventriculography and exercise multipl

ated cardiac blood pool imaging in the diagnosis and as-
essment of patients undergoing bypass graft surgery. In
ddition, results of bypass graft surgery will be discussed
patients with stable angina pectoris and those with se-
ere left ventricular dysfunction.

OURSE DIRECTOR: Bertram Pitt, MD, Ann Arbor

RESIDING: Doctor Pitt

PEAKERS/SUBJECTS:

oseph Walton, MD, Department of Cardiology, University
f Michigan Medical School
"Angiographic Evaluation and Assessment of Patients"
ames Thrall, MD, Division of Nuclear Medicine, Univer-
ty of Michigan Medical School
"Radionuclide Assessment and Evaluation of Patients"
ichard Foster, MD, Veterans Administration Hospital,
nn Arbor
"Unstable Angina — Implications for Patient Selection"
llis Jones, MD, Department of Surgery, Emery University
chool of Medicine, Atlanta
"Patients with Severe Ventricular Dysfunction"
icholas Kouchoukos, MD, University of Alabama in Bir-
ingham
"Coronary Artery Bypass Graft Surgery in Patients With Angina Pectoris — Surgical Results"

☐ Sexuality: New Recognition or Another Perspective of an Old Subject

RESENTED BY: Michigan Society of Physical Medicine
d Rehabilitation

his course will review the frequent sexual dysfunctions of
dividuals, the complex sexual problems associated with
pe, incest and sexual variations and the medically-related
xual problems associated with physical disabilities. Em-
asis will be given to learning about sexuality through un-
rstanding of self, assimilation of knowledge, and using
ese capabilities to the benefit of patients and their
milies.

URSE DIRECTOR: Charles J. Danek, MD, Ann Arbor

RESIDING: Doctor Danek

EAKERS:

eodore M. Cole, MD, Professor and Chairman, Depart-
ent of Physical Medicine and Rehabilitation, University
Michigan Medical School

ndra Cole, Instructor, Department of Physical Medicine
d Rehabilitation, Department of Psychiatry, University
Michigan Medical School

☐ What's New and Practical in Office Endocrinology?

RESENTED BY: Division of Endocrinology, Wayne State
niversity School of Medicine

is course is designed to provide the community physi-
n with a physiologic and practical approach to the diag-
sis of common endocrine problems, such as thyroid disorders, hypercalcemia, dwarfism and others. Case histories will be employed to enhance diagnostic abilities.

COURSE DIRECTOR: Subhash C. Gulati, MD, Detroit

PRESIDING: Doctor Gulati

SPEAKERS/SUBJECTS:

Subhash C. Gulati, MD, FRCP, Assistant Professor of Medicine, Chief of Endocrinology, Harper-Grace Hospital, Detroit and Acting Chief of Endocrinology, Wayne State University.
"Old and New Thyroid Function Tests"
A. Robert Arnstein, MD, Clinical Professor of Medicine, Wayne State University; Endocrinologist, William Beaumont Hospital, Royal Oak
"Pathophysiology of disorders of Calcium, Homeostasis"
Richard Landau, MD, Professor of Medicine, Section of Endocrinology, University of Chicago
"New Approaches to the Treatment of Infertility in Men and Women"
Subhash C. Gulati, MD, FRCP,
Clinical Case Presentations:
"Unusual Case of Hyperthyroidism"
"Work-up in Case of Hypercalcemia"
"Work-up of Infertility"

☐ What's New in Anti-Arthritics, Beta-Blockers, Bronchodilators and Vasodilators with Special Attention to New Agents and Drug Interactions

PRESENTED BY: MSMS Section on Clinical Pharmacology

This course, designed for all practicing physicians, will discuss the pharmacologic actions and principles for the use of four classes of pharmacologic agents — antiarthritics, beta-blockers, bronchodilators and vasodilators. There will be special emphasis on new agents and drug interactions. Formal presentations, panel discussion, and a question forum will be employed. A drug interaction pocket disc will be given to each participant.

COURSE DIRECTOR: George L. Royer, Jr., MD, Kalamazoo

PRESIDING: Doctor Royer

SPEAKERS/SUBJECTS:

Joann Data, MD, PhD, Research Physician, Internal Medicine and Clinical Pharmacology, The Upjohn Company, Kalamazoo
"Present Uses of Vasodilators"
John Weg, MD, Professor of Internal Medicine and Physician-In-Charge, Pulmonary Division, University of Michigan Medical School
"Bronchodilators"
Arthur Scherbel, MD, Head, Department of Rheumatic Diseases, Cleveland Clinic Foundation, Cleveland
"New Uses of Anti-Inflammatory Analgesic Agents"
Benedict Lucchesi, MD, PhD, Professor of Pharmacology, University of Michigan Medical School
"Current Therapy with Beta-Blockers"
Brian Whiting, MD, CHB, Senior lecturer in Clinical Pharmacology, University of Glasgow, Scotland
"Drug Interactions with Vasodilators, Bronchodilators, Beta-Blockers and Antiarthritic Drugs"

57 COURSES OFFER 3 HOURS OF CATEGORY I CREDIT

Courses Wednesday Morning, Nov. 8

☐ Advanced Cardiac Life Support (A 16-hour course to run all day Wednesday and Thursday)

PRESENTED BY: The Annual Scientific Meeting Committee and Michigan Heart Association

This course provides instruction in the following: (1) use of adjunctive equipment; (2) arrhythmia recognition and cardiac monitoring; (3) defibrillation and cardioversion; (4) establishing and maintaining intravenous fluid lifelines; drug therapy to correct acidosis, shock, and serious rhythmias; and (6) stabilization of the patient's condi for transportation. Course participants who successf complete the testing will be certified as providers in A by the Michigan Heart Association.

COURSE DIRECTOR: Daniel T. Anbe, MD, Detroit

ALL COURSES RUN FROM 8:30 TO NOON WITH HALF-HOUR BREAK

☐ Common Errors in Pediatric Management

PRESENTED BY: Department of Pediatrics, Wayne State University School of Medicine; Michigan Chapter, American Academy of Pediatrics

Experts in the field of pediatrics will be discussing the pathophysiology of various conditions, along with the more common errors in the management of clinical situations. This session will help physicians delivering primary pediatric care to make the most valid therapeutic choices.

COURSE DIRECTOR: Ralph Cash, MD, Detroit

PRESIDING: Doctor Cash

SPEAKERS/SUBJECTS:

Sanford N. Cohen, MD, Chairman, Department of Pediatrics, Wayne State University School of Medicine and Pediatrician-in-Chief, Children's Hospital

Jeanne Lusher, MD, Professor of Pediatrics, Wayne State University School of Medicine and Director of Hematology, Children's Hospital
"The Child with Anemia"

D. Michael Foulds, MD, Assistant Professor of Pediatrics, Wayne State University School of Medicine and Director, General Medical Clinics, Children's Hospital
"The Child with Pyuria"

Lester Baker, MD, Professor of Pediatrics, University of Pennsylvania and Director, Clinical Research Center, Children's Hospital of Philadelphia
"The Child with Diabetes"

Allen Sosin, MD, Clinical Assistant Professor of Pediatrics, Wayne State University School of Medicine
"The Child with Allergies"

Reuben Dubois, MB, MRACP, Associate Professor of Pediatrics, Wayne State University School of Medicine and Director, Gastroenterology, Children's Hospital
"The Child with Diarrhea"

☐ Diagnosis and Treatment of Common Esophageal Disorders

PRESENTED BY: Section of Thoracic Surgery, University of Michigan Medical School

This course, through two 1-hour lectures, case studies and discussion by family physicians, will provide primary care physicians with a review and updating of basic principles in the diagnosis and management of common esophageal disorders — both benign and malignant. Speakers will describe the various diagnostic studies now available evaluating esophageal dysfunction. These include: bar swallow examination, esophageal manometry and in esophageal acid reflux testing, esophagoscopy and 24-h monitoring of esophageal pH and motor function.

COURSE DIRECTOR: Mark B. Orringer, MD, Ann Ar

PRESIDING: Doctor Orringer

SPEAKER/SUBJECT:

Mark B. Orringer, MD, Associate Professor of Surg Section of Thoracic Surgery and Director, Thora Surgery Esophageal Clinic, University of Michigan M cal School
"Diagnosis and Treatment of Common Esophageal orders"

Panel Discussion: Question and Answer period by Far Physicians

☐ Diagnosis and Treatment of Patients w Hematologic Disorders

PRESENTED BY: Department of Internal Medici Wayne State University School of Medicine

This course will aid the practicing physician in dea more effectively with patients with various hematolo disorders. Practical information and basic science will presented through the use of lectures and cases on the pics: Microcytic Hypochromic Anemias; Effects of cohol on the Hemopoietic System; and the Lympho (emphasis on non-Hodgkins).

COURSE DIRECTOR: Carter R. Bishop, MD, Detroit

PRESIDING: Doctor Bishop

SPEAKERS/SUBJECTS:

Carter R. Bishop, MD, Professor of Medicine, Wayne St University School of Medicine and Chief of Medicine, troit General Hospital
"The Microcytic Hypochromic Anemias"

John D. Hines, MD, Case-Western Reserve School Medicine, Metropolitan Hospital, Cleveland
"The Effects of Alcohol on the Hemopoietic System

Ila Shah-Reddy, MD, Instructor, Department of Inte Medicine, Wayne State University School of Medicine
"The Lymphomas"

☐ Diagnosis and Treatment of Pneumonia and Legionnaires' Disease

RESENTED BY: Michigan Department of Public Health,
ichigan Public Health Officers Association and Michigan
ıblic Health Association

ıeumonia continues to be a common disease and its med-
al management can sometimes be a problem. The discov-
y of the agent of "Legionnaires' Disease" as a relatively
ıcommon, but potentially serious cause of pneumonia
rces a reassessment of the handling of pneumonia pa-
ents. This course is designed to give a general review of
e management of pneumonia patients with special em-
ıasis on "Legionnaires' Disease."

OURSE DIRECTOR: Kenneth R. Wilcox, MD, Lansing

RESIDING: Doctor Wilcox

EAKERS:

ouis D. Saravolatz, MD, Henry Ford Hospital, Detroit
orris Dumoff, MD, McLaren Hospital, Flint
ancis M. Wilson, MD, St. John Hospital, Detroit

☐ Evaluation of the Dizzy Patient for the Family Physician

RESENTED BY: Michigan Otolaryngological Society

ıis course will aid the family practitioner in evaluating
e dizzy patient. Emphasis will be placed on the use of
story, physical, X-ray, laboratory and audiological as-
ects of diagnosis.

O-COURSE DIRECTORS: Eugene Rontal, MD, South-
eld and **Michael Rontal, MD,** Southfield

RESIDING: Doctors Eugene and **Michael Rontal**

EAKERS:

ıgene Rontal, MD, Assistant Clinical Professor, Wayne
ate University School of Medicine and Clinical Instruc-
r, Otorhinolaryngology, University of Michigan Medical
hool
ichael Rontal, MD, Assistant Clinical Professor, Wayne
ate University School of Medicine and Clinical Instruc-
r, Otorhinolaryngology, University of Michigan Medical
hool
hn C. Webster, MD, Clinical Assistant Professor,
olaryngology, Wayne State University School of
edicine

☐ Lead Poisoning — An Update

RESENTED BY: Michigan Occupational Medical Associ-
ion

ıis course will present an update on changes in lead
age in industry, in the environment, at work, at home and in leisure activities. Current diagnosis and treatment of lead poisoning in these areas will be discussed.

COURSE DIRECTOR: William L. Knapp, MD, Detroit

PRESIDING: Doctor Knapp

SPEAKERS/SUBJECTS:

Marvin D. Anderson, MD, Assistant Clinical Professor of Medicine, University of Michigan Medical School
"Clinical Aspects of Lead Poisoning in Adults"
Douglas J. Wood, MD, Medical Director, Cadillac Motor Car Division, General Motors Corporation, Detroit
"Current Industrial Aspects of Lead Exposure"
Regina Aronow, MD, Director, Poison Control Center, Children's Hospital of Michigan; Associate Professor, Wayne State University
"Clinical Aspects of Lead Poisoning in Children"

☐ New Concepts in Peptic Ulcer Disease — New Approaches to Obstructive Jaundice

PRESENTED BY: Michigan Society for Gastrointestinal Endoscopy

This course will be divided into two parts. It will provide practical information about 1) new concepts of treatment of actively and non-actively bleeding patients with peptic ulcer disease and 2) how to arrive at a rational plan to make the proper diagnosis in a patient with obstructive jaundice using several new modalities. The rationale for each decision in diagnostic test and each therapeutic modality will be discussed.

COURSE DIRECTOR: John P. Papp, MD, Grand Rapids

PRESIDING: Eugene Gelzayd, MD, Southfield, **Edmund Martin Barbour, MD,** Dearborn and **Doctor Papp**

SPEAKERS/SUBJECTS:

First Session (including panel discussion):
Donald H. Kuiper, MD, Lansing
"Use of Antacids and Anticholinergics in Peptic Ulcer Disease"
Luis Maas, MD, Southfield
"Use of Tagamet in Peptic Ulcer Disease"
Robert Dale Brouwer, MD, Kalamazoo
"X-ray vs. Endoscopic Usefulness in Routine and Upper Gastrointestinal Bleeding Patients"
John P. Papp, MD, Grand Rapids
"Endoscopic Electrocoagulation in Upper Gastrointestinal Hemorrhage"
Arthur Klass, MD, Southfield
"Laser Coagulation in Upper Gastrointestinal Hemorrhage"
Norman W. Thompson, MD, Ann Arbor
"A Surgeon's View of Peptic Ulcer Disease"
Second Session (including panel discussion):
James Karo, MD, Southfield
"Usefulness of Ultrasound in Obstructive Jaundice"
Ramon R. Joseph, MD, Eloise
"The Chiba Needle in Obstructive Jaundice"

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Continued List of Speakers for Course on Peptic Ulcer

Stanley R. Strasius, MD, Ann Arbor
"Endoscopic Retrograde Cholangiopancreatography In Obstructive Jaundice"
Dominic Wong, MD, Detroit
"Laparoscopy in Obstructive Jaundice"
Gustav A. Uhlich, MD, Petoskey
"The Differential Diagnosis in Obstructive Jaundice"
Charles M. Asplund, MD, Big Rapids
"A Surgical View of Obstructive Jaundice"

☐ Newer Developments in Diagnosis and Treatment of Neurological Problems

PRESENTED BY: Department of Neurology, Wayne State University School of Medicine

This course is an overview of recent advances in Neurology.

COURSE DIRECTOR: John Gilroy, MD, Detroit

PRESIDING: Doctor Gilroy

SPEAKERS/SUBJECTS:

John Gilroy, MD, Professor and Chairman, Department of Neurology, Wayne State University, Detroit
"Recent Advances in Neurology and an Overview"
Raymond B. Bauer, MD, Professor of Neurology, Wayne State University, Detroit
"Use of Aspirin and Other Medicines in the Treatment of TIA and Stroke"
Roger M. Morrell, MD, Professor of Neurology
"Recent Advances in the Pathogenesis and Treatment of Amiotrophic Lateral Sclerosis and Multisclerosis"

☐ Office Dermatology for the Non-Dermatologist

PRESENTED BY: Michigan Dermatological Society

This course will utilize speakers and panel discussions to enable the practicing physician to recognize common dermatologic disorders, to know what lab tests to order, and how to manage common disorders with various treatment modalities. Specific subjects that will be covered are hair loss, superficial fungus infections, acne, leg dermatitis, and ulcers, as well as common benign and malignant tumors of the skin.

COURSE DIRECTOR: Thomas F. Downham, II, MD, Detroit

PRESIDING: Doctor Downham

SPEAKERS/SUBJECTS:

James D. Stroud, MD, Clinical Assistant Professor of Dermatology, Wayne State University School of Medicine
"Hair: The Lack Of It"
"Superficial Fungus Disease"
Warren J. Redmond, MD, Instructor of Dermatology, Wayne State University School of Medicine
"Acne Vulgaris"
Thomas A. Chapel, MD, Associate Professor of Dermatol ogy, Wayne State University School of Medicine
"Stasis Dermatitis & Stasis Ulcer"
Thomas F. Downham, II, MD, Assistant Professor of Der matology, Wayne State University School of Medicine
"Benign & Malignant Skin Tumors"

☐ Office Gynecology for Non-Gynecologists

PRESENTED BY: Department of Obstetrics/Gynecology William Beaumont Hospital

This course, for the non-gynecologist, will give an overview of the basic oncology, pelvic infections an gynecologic endocrinology needed in office gynecology. A panel discussion will follow each of the three primary presentations.

COURSE DIRECTOR: R. Ralph Margulis, MD, Royal Oak

PRESIDING: Doctor Margulis

SPEAKERS/SUBJECTS:

R. Ralph Margulis, MD, Associate Professor of Obstetrics/Gynecology, Wayne State University School o Medicine and Associate Medical Director for Clinical Affairs, William Beaumont Hospital, Royal Oak
"Gynecologic Endocrinology"
Alfred I. Sherman, MD, Professor of Obstetrics/Gynecology, Wayne State University School of Medicine and Director, Gynecology/Oncology, William Beaumont Hospital, Royal Oak
"Oncology"
S. Leonard Cohn, MD, Adjunct Instructor, Obstetrics Gynecology, Wayne State University School of Medicine Senior Attending Staff, William Beaumont Hospital, Royal Oak
"Pelvic Infections"

☐ What's New in Surgery?

PRESENTED BY: Department of Surgery, Michigan State University College of Human Medicine

This course will provide information on new advances an clinical applications in surgery, through presentations an discussion by surgeons with expertise and interest in both general surgery and its specialties.

COURSE DIRECTOR: Dan C. English, MD, East Lansing

PRESIDING: Doctor English

SPEAKERS/SUBJECTS:

James M. Harkema, MD, Assistant Professor of Surgery Michigan State University College of Human Medicine
"New Approaches to Obstructive Jaundice"
Imad F. Tabry, MD, Assistant Professor of Surgery Michigan State University College of Human Medicine
"New Trends in Cardiac Surgery"
Y. Pal Kapur, MD, Professor of Surgery, Michigan State University College of Human Medicine
"Cochlear Implants — Current Concepts"
W. David Moore, MD, Clinical Instructor of Surgery Michigan State University College of Human Medicine
"Recent Developments in Post-Mastectomy Reconstruction"

FILL IN REGISTRATION FORM ON PAGE 19, MAIL TO MSMS

dnesday Morning Continued

hard E. Dean, MD, Professor of Surgery, Michigan te University College of Human Medicine
'Recent Insights into Nutrition and Surgery''

ul Jakubiak, MD, Associate Clinical Professor of rgery, Michigan State University College of Human dicine
'Cerebral Revascularization: A Breakthrough''

L. Jean Dunegan, MD, Assistant Professor of Surgery, Michigan State University College of Human Medicine
''Vascular Operations: Are We Still Living in the Past? Can We Meet the Future?''

FILM: ''The Treatment of Chondromalacia of the Patella with the Intra-Articular Shaver'' (Lanny L. Johnson, MD, Clinical Professor of Surgery, Michigan State University College of Human Medicine).

Courses Wednesday Afternoon, Nov. 8

ALL COURSES RUN FROM 1:30 TO 5:00 WITH HALF-HOUR BREAK

☐ Congestive Heart Failure — New Concepts in Evaluation and Therapy

ESENTED BY: Division of Cardiology, University of chigan Medical School

is course will cover the use of new radioactive tracer hniques and echocardiographic techniques in the evalu-n of patients with congestive heart failure. In addition, w concepts in the use of vasodilator therapy and iono-pic agents would be discussed.

URSE DIRECTOR: Bertram Pitt, MD, Ann Arbor

ESIDING: Doctor Pitt

EAKERS/SUBJECTS:

eph A. Walton, Jr., MD, Assistant Professor of Internal dicine, University of Michigan Medical School
'Assessment of Ventricular Function by Angiography''

rtram Pitt, MD, Professor of Internal Medicine and Di-tor, Division of Cardiology, University of Michigan dical School
'Evaluation of Patients with Congestive Heart Failure y Radioactive Tracer Techniques''

hard Sorkin, MD, Instructor in Internal Medicine, Uni-sity of Michigan Medical School
'Evaluation of Patients with Congestive Heart Failure y Echocardiographic Techniques''

nil K. Das, MD, Associate Professor of Internal dicine, University of Michigan Medical School
'Vasodilator Therapy in Congestive Heart Failure''

nedict R. Lucchesi, MD, PhD, Professor of Pharmacol-, University of Michigan Medical School
'Ionotropic Agents in the Therapy of Congestive Heart ailure''

☐ Cost Awareness and Medical Care

PRESENTED BY: MSMS Committee on Medical Care Costs

This course is designed for every physician in Michigan to study the cost awareness activities of the Michigan State Medical Society and others as the medical profession seeks to maintain quality medical care while seeking ways to increase cost consciousness and cost effectiveness. In addition to philosophical discussions by the presidents of the Michigan State Medical Society and the Michigan Hospital Association, the session 1) will describe an experience in Grand Rapids concerning open heart surgery and medical costs and, 2) will present an address by the house officer whose paper is chosen best among those presented in a contest conducted by the Michigan Association for Medical Education.

COURSE DIRECTOR: Charles R. Zimont, MD, Constantine

PRESIDING: Doctor Zimont

SPEAKERS/SUBJECTS:

James Sammons, MD, Executive Vice President, American Medical Association, Chicago (tentative)
''Cost Awareness — The Medical Profession is Providing National Leadership''

Louis E. Heideman, MD, Detroit, President, Michigan State Medical Society
''Cost Awareness — Relationship to Everyday Medical Practice''

John C. Bay, MD, Administrator, Munson Hospital, Traverse City and President, Michigan Hospital Association
''Cost Awareness — Relationship to Hospital Operations''

Luis A. Tomatis, MD, Grand Rapids
''Cost Awareness — An Experience in Open Heart Surgery''

Presentation by Winner of Essay contest by Michigan Association for Medical Education: ''Cost Awareness — Relationship to Post-Graduate Medical Education''

REGISTRATION FORM, PAGE 19

Wednesday Afternoon Continued

☐ Current Concepts and Management of Common Pediatric Surgical Problems

PRESENTED BY: Department of Surgery, Wayne State University School of Medicine, Children's Hospital Surgical Department and Michigan Chapter, American Academy of Pediatrics

The course will acquaint pediatricians, family practitioners and general surgeons who treat pediatric-age patients with the current concepts in management of some of the more common pediatric surgical diseases. Lecture and discussion will cover surgical management problems encountered on a daily basis. The goal is to bring practitioners up-to-date and replace some of the persistent, long-standing misconceptions.

COURSE DIRECTOR: Jack H. Hertzler, MD, Detroit

PRESIDING: Doctor Hertzler

SPEAKERS/SUBJECTS:

Peter Gibson, MD, Attending Surgeon, Children's Hospital of Michigan
"Cryptorchidism — Current Approach"
Susan Adelman, MD, Assistant Attending Surgeon, Children's Hospital and Clinical Instructor, Wayne State University School of Medicine
"The Pediatric Ovary"
Patrick F. Jewell, MD, Attending Surgeon, Children's Hospital; Director, Surgical Education, St. John Hospital and Clinical Assistant Professor, Wayne State University School of Medicine
"Common Pediatric Gynecologic Problems"
Vollrad J. vonBerg, MD, Attending Surgeon and Associate Chief of Pediatric General Surgery, Children's Hospital and Clinical Assistant Professor, Wayne State University School of Medicine
"Appendicitis in Children"
Federico A. Arcari, MD, Attending Surgeon, Children's Hospital and Clinical Assistant Professor, Wayne State University School of Medicine
"Splenic Trauma — Current Management"
James R. Lloyd, MD, Attending Surgeon and Director of Burn Service, Children's Hospital and Clinical Assistant Professor, Wayne State University School of Medicine
"The Inflicted Burn — A Manifestation of Child Abuse"
Arvin I. Philippart, MD, Attending Surgeon and Chief of General Pediatric Surgery, Children's Hospital and Associate Professor of Surgery, Wayne State University School of Medicine
"Evaluation of Chronic Pulmonary Disease"

☐ Current Management of Hemorrhoids, Anal Fissures and Anal Fistulas

PRESENTED BY: Michigan Society of Colon and Rectal Surgeons

This course will utilize formal presentations, panel discussion and an audience question & answer period to present new concepts of treatment of hemorrhoids, anal fissures and anal fistulas in a practical and readily-usable format.

COURSE DIRECTOR: Thomas A. Fox, Jr., MD, Detroit

PRESIDING: Doctor Fox

SPEAKERS/SUBJECTS:

Hans J. Stein, MD, Division of Colon and Rectal Surgery
William Beaumont Hospital, Royal Oak
"Current Management of Anal Fissures"
John M. MacKeigan, MD, Practicing Colon and Recta
Surgeon, Ferguson Clinic, Grand Rapids
"Current Management of Anal Fistulas"
Eugene P. Salvati, MD, Division of Colon and Recta
Surgery, Muhlenberg Hospital, Plainfield, New Jersey
"Current Management of Hemorrhoids"

☐ Cutaneous Manifestations of Systemic Disease

PRESENTED BY: Michigan Dermatological Society

This course will review current progress of specific diseases associated with systemic disease. Speakers will emphasize Cutaneous Manifestations of Systemic Disease and therapy, such as, vasculitis and enteropathy associated with dermatitis herpetiformis. A panel discussion with questions from the participants will follow.

COURSE DIRECTOR: Thomas F. Downham, II, MD, Detroit

PRESIDING: Doctor Downham

SPEAKERS/SUBJECTS:

Irwin M. Braverman, MD, Professor of Dermatology, Yale University School of Medicine, New Haven, Connecticut
"Vasculitis"
Stephen I. Katz, MD, PhD, Senior Investigator, Dermatology Branch, National Cancer Institute, Bethesda, Maryland
"Dermatitis Herpetiformis: Skin and the Gut"
"Herpes Gestationis"

☐ Dealing with Women Patients

PRESENTED BY: Committee for Women, Michigan Psychiatric Society

This course will examine various psychological issues concerning the woman patient and her emotional response to illness, to various medical-surgical procedures and most important, to her physician. Ways to improve the doctor-patient relationship will be considered.

COURSE DIRECTOR: Linda Logsdon, MD, Southfield

PRESIDING: Doctor Logsdon

SPEAKERS/SUBJECTS:

Kenneth R. Silk, MD, Clinical Instructor in Psychiatry, University of Michigan Medical School and Staff Psychiatrist, Veteran's Administration Hospital, Ann Arbor
"Introduction — Clinical Vignettes"
Malkah Notman, MD, Consultant in Obstetrics-Gynecology, Associate Clinical Professor of Psychiatry, Harvard University Medical School, Boston
"The Patient-Doctor Relationship"
Mel I. Barclay, MD, Assistant Professor of Obstetrics-Gynecology, University of Michigan Medical School

☐ Diagnosis and Treatment of Allergy and Bronchial Asthma in Children

ESENTED BY: Michigan Allergy Society

is course will emphasize the need for early diagnosis and
timal treatment of bronchial asthma in children. The
urse content includes incidence, recognition in infancy,
fferential diagnosis, treatment of the acute attack, inpa-
ent status asthmaticus and office management of the
ronic asthmatic. New drug therapeutic modalities will be
nphasized as well as the value of pulmonary function and
ood theophylline monitoring. The use and value of im-
unotherapy for the allergic child and advice given to pa-
nts as to avoidance therapy will be touched upon. Final-
, the value of food skin testing and diet therapy in bronc-
l asthma management will be discussed.

OURSE DIRECTOR: John A. Anderson, MD, Detroit

ESIDING: Doctor Anderson

EAKERS/SUBJECTS:

illiam A. Howard, MD, Clinical Professor of Pediatrics,
eorge Washington University Medical School and Emer-
us Chairman, Department of Allergy, Children's Hospital
ational Medical Center, Washington, D.C.
''Allergy and Bronchial Asthma in Children''
elen A. Papaioanou, MD, Pediatric Allergist, Grosse
inte Woods
''Allergy and Bronchial Asthma in Children''
hn A. Anderson, MD, Head, Division of Allergy and
inical Immunology, Henry Ford Hospital
''Allergy and Bronchial Asthma in Children''

☐ Diagnosis and Treatment of Common Rheumatic Disorders

ESENTED BY: Department of Internal Medicine, Ar-
ritis Division, University of Michigan Medical School

ie objective of this course is to outline the newest con-
pts of laboratory evaluation and treatment of rheumatoid
thritis, osteoarthritis, hyperuricemia and primary gout.
urse content will emphasize information of practical
lue to the family physician and general internist in the
agnosis and management of these disorders.

URSE DIRECTOR: Giles G. Bole, MD, Ann Arbor

ESIDING: Doctor Bole

EAKERS/SUBJECTS:

ra E. Walker, MD, Assistant Professor of Internal
edicine, University of Michigan Medical School
''Laboratory Evaluation of Rheumatoid Arthritis, Os-
teoarthritis and Gout''
iles G. Bole, MD, Professor of Internal Medicine and
ief, Athritis Division, University of Michigan Medical
hool
''Treatment of Rheumatoid Arthritis''
nald R. Kay, MD, Assistant Professor of Internal
edicine, University of Michigan Medical School
''Management of Osteoarthritis''
bert Wortmann, MD, Instructor, Internal Medicine,
niversity of Michigan Medical School
''Management of Hyperuricemia and Treatment of
Gout''

☐ Identification and Management of the High-Risk Obstetrical Patient

PRESENTED BY: Michigan Society of Obstetricians & Gynecologists, Michigan Section of the American College of Obstetricians and Gynecologists and the MSMS Section of Obstetricians and Gynecologists

In this course, a report on the Addicted Neonate and a summary of the statewide High Risk Prenatal Care Project of the Michigan Department of Public Health will be presented. Both the prenatal and intrapartum aspects of the problems of the high-risk obstetrical patient will be examined.

COURSE DIRECTOR: Charles W. Aldridge, Jr., MD, Grand Rapids

PRESIDING: Doctor Aldridge

SPEAKERS/SUBJECTS:

Robert J. Sokol, MD, Associate Professor of Obstetrics and Gynecology and Assistant Program Director, Perinatal Clinical Research Center, Cleveland Metropolitan General Hospital, Case Western Reserve University
''Antepartum Detection of Perinatal Risk''
Joan C. Stryker, MD, Associate Professor of Obstetrics and Gynecology, Wayne State University School of Medicine
''The Addicted Neonate''
Chang Yoon Lee, MD, Chairman, Division of Maternal-Fetal Medicine, Henry Ford Hospital
''The Identification of High-Risk During Labor''
Charles J. Berger, MD, Medical Chief, Division of Maternal and Infant Health, Michigan Department of Public Health
''Highlights of the Michigan High Risk Prenatal Care Project''

☐ Male Sexual Problems: Impotency, Infertility

PRESENTED BY: Michigan Branch, American Urological Association

This course will review current methods of evaluation and treatment of infertility and impotence. The course will help the primary physician be able to evaluate men with these sexual problems and treat or advise them.

COURSE DIRECTOR: Gerald F. Conway, MD, Royal Oak

PRESIDING: Joseph Oldford, MD, Farmington Hills

SPEAKERS/SUBJECTS:

Robert Anderson, MD, Clinical Instructor in Surgery (Urology) and Internal Medicine and Director of Health Service, University of Michigan Medical School
''Medical Evaluation and Management of Infertility''
Vincent O'Conor, MD, Professor of Urology, Northwestern University College of Medicine, Chicago
''Current Surgical Therapy of Infertility''
Ananias Diokno, MD, Associate Professor of Surgery (Urology), University of Michigan Medical School
''Surgical Treatment of Impotence''
Anthony Thomas, MD, Assistant Professor of Urology, Wayne State University School of Medicine
''Treatment of Non-Organic Impotence''

☐ Nuclear Medicine — Review of Current Applications and New Developments

PRESENTED BY: Michigan College of Nuclear Medicine Physicians

This course, consisting of several 30-40 minute talks, is directed at the practicing physician wishing to learn about new uses and techniques of nuclear medicine, proper utilization of nuclear tests and interpretation of results for bone, cardiac, tumor/infection and radioimmunoassay studies. Practical applications will be emphasized.

COURSE DIRECTOR: Daniel S. Marks, MD, Detroit

PRESIDING: Doctor Marks

SPEAKERS/SUBJECTS:

Daniel S. Marks, MD, Chief, Division of Nuclear Radiology, Henry Ford Hospital, Detroit
"Multiple Uses for Bone Imaging — and Why These Can be More Revealing than X-ray Studies"
Howard Dworkin, MD, Chief, Nuclear Medicine, William Beaumont Hospital, Royal Oak
"Radionuclides and the Heart: Myocardial Imaging and Functional Analysis"
Darlene Fink-Bennett, MD, Staff Physician, Nuclear Medicine, William Beaumont Hospital, Royal Oak
"Infection and Tumor Detection Studies"
Malcolm E. Williamson, DO, Director, Nuclear Medicine, Riverside Osteopathic Hospital, Trenton
"Radioimmunoassay — Use and Interpretation in Endocrine and Other Disorders"
Panel Discussion: "Anything You Want to Know About Nuclear Medicine, But Did Not Have the Time to Ask"

☐ Physicians and Their Families

PRESENTED BY: The Annual Scientific Meeting Committee, Michigan Academy of Family Physicians and Michigan State Medical Society Auxiliary

This course, through lecture and discussion, will explore the improvement of relationships between physicians and members of their families. Special emphasis will be placed on relationships between the physician, the grandparents and adolescents in the family. Other areas of special interest to be discussed are the impaired physician within the family and special problems of the single parent. Course participants should be better able to recognize and provide, or seek, counsel in these problem areas.

COURSE DIRECTOR: Donald E. DeWitt, MD, Kalamazoo

PRESIDING: Doctor DeWitt

SPEAKERS/SUBJECTS:

Beverly T. Mead, MD, Professor and Chairman, Department of Psychiatry, Creighton University School of Medicine, Omaha, Nebraska
"How to Live With a Doctor"
Douglas A. Sargent, MD, President-Elect, Michigan Psychiatric Society, and Chairman, MPS Committee on Well-Being of Physicians
"Alcohol Problems Facing the MD and Members of Family"
Ray O. Creager, MD, Practicing Child Psychiatrist, and Director, Kalamazoo Child Guidance Center
"One-Parenting Syndrome"
Donald E. DeWitt, MD, President-Elect, Michigan Academy of Family Physicians and Director, Family Practice Residency Program, SMAHEC, Kalamazoo
"Responsibilities and Life with Grandma and Grandpa"
Natalia Tanner, MD, FAAP, Clinical Associate Professor of Pediatrics, Wayne State University School of Medicine
"Adolescents and Their Medical Parents"

☐ Poisonings in the Emergency Department

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course will discuss the management of the coma patient and the general approach to patients with poisoning and overdose. Specific attention will be paid to PCP poisoning and Tricyclics.

COURSE DIRECTOR: Ronald L. Krome, MD, Detroit

PRESIDING: John VanDeLeuv, MD, Wyandotte

SPEAKERS/SUBJECTS:

Judith E. Tintinalli, MD, Assistant Professor of Emergency Medicine, Wayne State University School of Medicine
"Management of the Coma Patient"
Thomas J. Petinga, Jr., DO, Clinical Instructor of Emergency Medicine, Wayne State University School of Medicine
"Poisonings and Overdoses"
Alan K. Done, MD, Professor of Pediatrics and Pharmacology, Wayne State University School of Medicine
"PCP Abuse"
Les Haddad, MD, Chairman, American College of Emergency Physicians Committee on Clinical Toxicology, Savannah, Georgia
"Tricyclics"

FILL IN REGISTRATION FORM ON PAGE 19, MAIL TO MSMS

Courses Thursday Morning, Nov. 9

ALL COURSES RUN FROM 8:30 TO NOON WITH HALF-HOUR BREAK

☐ Diagnosis and Treatment of Common Athletic Injuries

is course is designed for the physician whose practice
cludes the initial care and treatment of injuries of the
mpetitive athlete as well as recreational injuries. Em-
asis will be on diagnosis and treatment and some of
pitfalls in the treatment of sports injuries.

OURSE DIRECTOR: Gerald A. O'Connor, MD, Ann
bor

RESIDING: Doctor O'Connor

EAKERS/SUBJECTS:

illiam Clancy, Jr., MD, Assistant Professor, Ortho-
edic Surgery, Team Physician, University of Wisconsin,
adison, Wisconsin.
"Runners Injuries"

omas R. Peterson, MD, Ann Arbor, Assistant Clinical
fessor of Orthopaedic Surgery, University of Michigan.
'Physical Variations Compatible with Athletic Competition"

aldomar Roeser, MD, Ypsilanti; Team Physician, Eastern
chigan University
"Shoulder Problems in the Athlete"

illiam Clancy, Jr., MD, Madison, Wisconsin, Assistant
ofessor, Orthopaedic Surgery, Team Physician, Univer-
y of Wisconsin
'Arthrography and Arthroscopy — Acute Knee Injury"

tha Hunter, MD, Instructor, Orthopaedic Surgery, Uni-
rsity of Michigan Medical Center
"The Woman Athlete — Facts and Fancies"

win Guise, MD, Chief, Orthopaedic Surgery, Ford Hos-
al, Team Physician, Detroit Lions, Detroit
'Ankle Problems in the Athlete"

☐ Diuretic Therapy: Applications and Complications

RESENTED BY: Division of Nephrology, University of
ichigan Medical School

this course, a sequence of talks will deal with such as-
cts of diuretic therapy as the mechanism of action of
uretic agents; the fluid and electrolyte complications of
erapy; the impact of diuretics on calcium homeostasis
d the role of diuretics in the management of nephro-
hiasis and hypercalcemia.

OURSE DIRECTOR: Richard L. Tannen, MD, Ann
bor

RESIDING: Doctor Tannen

EAKERS/SUBJECTS:

ien Hsing Hsu, MD, Associate Professor of Medicine,
iversity of Michigan Medical School
"Mechanism of Action of Diuretic Drugs"

chard L. Tannen, MD, Professor of Medicine, University
Michigan Medical School
"Fluid and Electrolyte Complications of Diuretic Therapy"

ik-kai Lau, MD, Assistant Professor of Medicine, Uni-
rsity of Michigan Medical School
"Diuretics in the Therapy of Nephrolithiasis and Hypercalcemia"

☐ Exercise in Medicine: Controversies, Indications, Proper Prescribing and Precautions

PRESENTED BY: Department of Family Medicine, Wayne Sate University School of Medicine

This course will introduce the concept of exercise as an alternative to medication as a treatment modality. The session will consist of 2 hours of lecture and slides, along with an hour of case examples and discussion forum. Case examples will deal with weight control, reduction of alcohol, absence of cigarettes, dietary manipulation and endurance training. After this course, the physician should be able to employ basic techniques of patient education and behavior modification toward patient motivation.

CO-COURSE DIRECTORS: Joseph Arends, MD, Troy and **Fred Stransky, PhD,** Rochester

PRESIDING: Doctors Arends and Stransky

SPEAKERS/SUBJECTS:

Joseph Arends, MD, Instructor, Wayne State University School of Medicine
"The Definition of Normal versus Average"

Fred Stransky, PhD, Exercise Physiologist, Oakland University, Rochester
"The Anatomical, Physiological and Biochemical Adaptations to Endurance Training"

☐ Frequent Problems in ECG Interpretation

PRESENTED BY: Department of Medicine, Wayne State University School of Medicine

Through case presentations, this course will illustrate differentiating points in ECG interpretation of especially problematic tracings. Speakers will help sharpen skills in diagnosis of certain supraventricular arrhythmias, in differentiating acute myocardial infarction from other mimicking ECG presentations, and in electrocardiographic assessment of cardiac pacemaker function.

COURSE DIRECTOR: Franklin E. Hull, MD, Detroit

PRESIDING: Doctor Hull

SPEAKERS/SUBJECTS:

Frederick Talmers, MD, Professor of Medicine, Wayne State University School of Medicine and Director, Section of Cardiology, Veteran's Administration Hospital, Allen Park
"Differential Diagnosis of Problematic Supraventricular Arrhythmias"

Franklin E. Hull, MD, Director of Cardiology Division, Professor of Medicine, Wayne State University School of Medicine and Director, Section of Cardiology, Harper-Grace Hospital
"Problems in ECG Diagnosis of Myocardial Infarction"

Marcia Fowler, MD, Assistant Professor of Medicine, Wayne State University School of Medicine and Director, Coronary Care Unit, Hutzel Hospital, Detroit
"Problems in ECG Assessment of Cardiac Pacemaker Function"

☐ Immunology and Inflammatory Bowel Disease

PRESENTED BY: National Foundation Ileitis and Colitis

This course will review basic immunological concepts, discuss immunological aspects of IBD and give an overview of the treatment of IBD with special emphasis on adrenocorticosteroids and immunosuppressive drugs.

COURSE DIRECTOR: Manuel Sklar, MD, Detroit

PRESIDING: Doctor Sklar

SPEAKERS/SUBJECTS:

Noel Rose, MD, Professor of Immunology and Microbiology, Wayne State University School of Medicine
"A Review of Basic Immunological Concepts"
Summer Kraft, MD, Professor of Medicine, University of Chicago Medical School
"Immunological Aspects of Inflammatory Bowel Disease"
Eugene Winkelman, MD, Attending Physician, Department of Gastroenterology, Cleveland Clinic
"Therapeutic Principles in the Management of Inflammatory Bowel Disease"

☐ Interpreting the Biochemical Profile

PRESENTED BY: Departments of Pathology, Henry Ford Hospital, St. John Hospital and University of Michigan.

The goal of this course is to present some practical considerations relative to the interpretation of biochemical profiles. To be included will be a review of "typical" profiles, statistical considerations in interpreting biochemical data, and discussions on the abnormal alkaline phosphatase, liver function testing and CPK isoenzymes.

COURSE DIRECTOR: Kenneth A. Greenawald, MD, Detroit

PRESIDING: Doctor Greenawald

SPEAKERS/SUBJECTS:

Kenneth A. Greenawald, MD, PhD, Chairman, Department of Pathology, Henry Ford Hospital, Detroit
"Biochemical Profiles: A Review of Representative Patterns"
Noel Lawson, MD, Associate Pathologist, St. John Hospital, Detroit, and Clinical Assistant Professor of Pathology, Wayne State Univeristy School of Medicine
"Statistical Considerations in Biochemical Profiling"
John Batsakis, MD, Professor of Pathology, Co-Director of Clinical Laboratories, University of Michigan Medical School
"The Unexpected Elevated Alkaline Phosphatase"
"The Liver Profile"
Craig Foreback, PhD, Acting Division Head, Clinical Chemistry Laboratory, Henry Ford Hospital, Detroit
"Isoenzymes of CPK and LDH as an Aid to Diagnosing Myocardial Infarction"

☐ Nosocomial Infections: Recognition and Management

PRESENTED BY: Department of Medicine, Wayne State University School of Medicine

The occurrence (epidemiology), recognition, analyses and prevention of nosocomial infections will be presented. Also included will be presentations of these infections as relates to the use of intravenous fluids, specialized hospital procedures (e.g. cardiac catheterization) and cancer wards.

COURSE DIRECTOR: A. Martin Lerner, MD, Detroit

PRESIDING: Doctor Lerner

SPEAKERS/SUBJECTS:

Dennis G. Maki, MD, Associate Professor of Medicine and Chief, Infectious Disease Unit, University of Wisconsin Hospital, Madison
"Value and Manner of Monitoring Nosocomial Infections, Susceptibility Studies, Hospital Epidemiology and the Nurse Practitioner"
Carl B. Lauter, MD, Associate Professor of Medicine and Chief, Infectious Diseases, Harper-Grace Hospital, Wayne State University School of Medicine
"Nosocomial Infections on a Cancer Service"
Ralph D. Cushing, MD, Associate Professor of Medicine and Chief, Infectious Diseases, Detroit General Hospital, Wayne State University School of Medicine
"Nosocomial Infections from Intravenous Fluids"
Milagros P. Reyes, MD, Associate Professor of Medicine, Division of Infectious Diseases, Wayne State University School of Medicine
"Nosocomial Infections in a Cardiac Catheterization Laboratory"
A. Martin Lerner, MD, Professor of Medicine and Chief, Infectious Diseases, Wayne State University School of Medicine; Chief, Hutzel Hospital Medical Unit
"Nosocomial Infections and Treatment in Intensive Care, Urology, and Burn Units"

Thursday Morning Continued

☐ Role of Hyperalimentation in Common Medical and Surgical Disorders

PRESENTED BY: Department of Surgery, Michigan State University College of Human Medicine

This course will present a practical approach to the organization and management of a safe and efficient hyperalimentation (TPN) Service in the community hospital. Peripheral and central venous methods of delivery will be presented for the management of patients with surgical problems, the cancer patient and the patient with "gut failure" who is a candidate for home hyperalimentation. Case presentations and discussion periods will review the therapeutic options.

COURSE DIRECTOR: Richard E. Dean, MD, Grand Rapids

PRESIDING: Doctor Dean

SPEAKERS/SUBJECTS:

Richard E. Dean, MD, Professor of Surgery, Michigan State University College of Human Medicine
"Quality Assurance — A Function of the Nutrition Team"
"Home Hyperalimentation for the Patient with Gut Failure"

Jason Bodzin, MD, Chairman, Nutritional Support Team, Mount Carmel Mercy Hospital, Detroit
"Methods of Hyperalimentation in Surgery and Trauma"

Maurice Shils, MD, Director of Nutrition, Sloan-Kettering Memorial Hospital, New York
"Nutritional Support of the Cancer Patient"

☐ Scientific Medical Writing

PRESENTED BY: Michigan Chapter, American Medical Writers Association

After short lectures on topics of interest to the physician-writer, the session will be spent in a small group workshop discussing materials on literature research, manuscript organization and ways to identify and correct common writing flaws. Upon completion of this course, participants should be equipped with the basic principles needed to prepare scientific manuscripts for publication.

COURSE DIRECTOR: Archie Bedell, MD, Grosse Pointe

PRESIDING: Doctor Bedell

SPEAKERS:

Byron T. Scott, PhD, Ohio University School of Journalism, and President-Elect, American Medical Writers Association

Jeanne Tashian, Managing Editor, *Journal of Thoracic Surgery*

☐ Transplantation: Current Status and Future Prospects

PRESENTED BY: Department of Surgery, University of Michigan Medical School

The current status and prospects for improvements in transplantation will be reviewed. Special emphasis is given to related and cadaveric renal transplantation and to volunteer cadaveric donor nephrectomy. Results with other types of organ transplantation will be included. Vascular access for hemodialysis, comparison of cost and benefits of dialysis transplantation and other forms of therapy and the management of complications arising in the transplant patient will be discussed.

COURSE DIRECTOR: Jeremiah G. Turcotte, MD, Ann Arbor

PRESIDING: Doctor Turcotte

SPEAKERS/SUBJECTS:

William Bouman, MD, Nephrologist, St. Mary's Hospital, Grand Rapids
"Who Is a Candidate for Renal Transplantation"

John Konnak, MD, Associate Professor, Section of Urology, University Hospital, Ann Arbor.
"Related Donor Nephrectomy"

Duane Freier, MD, Chief of Surgery, Veterans Administration Hospital, Ann Arbor
"Related Renal Transplantation"

Robert Allaben, MD, Vice Chairman, Department of Surgery and Chief, Section of Transplantation, Mt. Carmel Hospital, Detroit
"Cadaveric Donor Nephrectomy"

Stanley Dienst, MD, Director, Transplantations, Henry Ford Hospital, Detroit
"Cadaveric Transplantation"

Jerry Rosenberg, MD, Chief of Surgery, Hutzel Hospital, Detroit
"Recent Advances and Prospects for Improvements in Transplantations"

Courses Thursday Afternoon, Nov. 9

ALL COURSES RUN FROM 1:30 TO 5:00 WITH HALF-HOUR BREAK

☐ Antibiotic Therapy — New Advances

PRESENTED BY: Department of Internal Medicine, University of Michigan Medical School

Upon completion of this course, the practicing physician, through a series of practical lectures about the recent advances in antibiotic therapy, will obtain knowledge of new antibiotics and understand new approaches to the problems of prophylaxis, penicillin allergy, and the septic patient.

COURSE DIRECTOR: Carol A. Kauffman, MD, Ann Arbor

PRESIDING: Doctor Kauffman

SPEAKERS/SUBJECTS:

Carol A. Kauffman, MD, Associate Professor of Internal Medicine, University of Michigan Medical School and Chief, Infectious Diseases Section, VA Hospital, Ann Arbor
"Newer Antibiotics"
John P. Phair, MD, Professor of Internal Medicine and Director, Division of Infectious Diseases, Northwestern University Medical School, Chicago
"Penicillin Allergy — Evaluation and Alternate Antibiotic Therapy"
John N. Sheagren, MD, Professor of Internal Medicine, University of Michigan Medical School and Chief, Medical Service, VA Hospital, Ann Arbor
"Approach to the Acutely Ill Febrile Patient"
David Katz, MD, Assistant Clinical Professor, University of Michigan Medical School and Head, Division of Infectious Diseases, St. Joseph Mercy Hospital, Ann Arbor
"What's New in Prophylaxis"

☐ Chronic, Non-Alcoholic Liver Disease

PRESENTED BY: Department of Internal Medicine, University of Michigan Medical School

Upon completion of this course, the attending internist or family physician will be able to: 1) Discriminate in the laboratory diagnosis of the jaundiced patient, 2) Identify benign forms of jaundice, 3) Discriminate between significant and non-significant forms of chronic hepatitis according to clinical, biochemical and histopathological parameters, 4) Diagnose primary biliary cirrhosis and 5) Understand Wilson's disease as a readily diagnosable and treatable disease.

COURSE DIRECTOR: Keith S. Henley, MD, Ann Arbor

PRESIDING: Doctor Henley

SPEAKERS/SUBJECTS:

Irwin M. Arias, MD, Professor of Medicine and Director, Liver Research Center, Albert Einstein College of Medicine, Bronx, New York
"The Jaundiced Patient"
Keith S. Henley, MD, Professor of Internal Medicine, Physician-In-Charge, Section of Gastroenterology, University of Michigan Medical School and **Henry D. Applemann, MD,** Professor of Pathology, University of Michigan Medical School
"Chronic Active Hepatitis"
Jorge J. Gumucio, MD, Assistant Professor of Interna Medicine, University of Michigan Medical School and **Henry D. Applemann, MD,** Professor of Pathology, University of Michigan Medical School
"Primary Biliary Cirrhosis"
"Chornic Active Hepatitis" and "Primary Biliary Cirrhosis"
Doctors Arias and Gumucio
"Wilson's Disease"

☐ Common Problems in Thoracic Surgery

COURSE DESCRIPTION:

This course is designed to help physicians who may be required to advise or initiate treatment in the true emergency of ingested lye or acid. Failure to institute prompt and effective treatment may be fatal. Recurrent pleural effusion will be discussed as to etiology and treatment of the condition and its complications. How to avoid completely missing thoracic outlet syndrome and the indications for and method of treating funnel chest will also be discussed.

PRESENTED BY: Michigan Society of Thoracic Surgeons

COURSE DIRECTOR: Raymond J. Barrett, MD, Southfield

PRESIDING: Doctor Barrett

SPEAKERS/SUBJECTS:

Walter Barker, MD, Chief, Pulmonary Surgery, Cook County General Hospital, Chicago
"Recurrent Pleural Effusions — A Vexing Problem"
Arvin L. Philippart, MD, Chief, Pediatric General Surgery Children's Hospital of Michigan, Detroit
"I Think Johnny Swallowed Lye — An Emergency"
Philip Bernatz, MD, Mayo Clinic, Rochester, Minnesota
"Pectus Excavatum — Should It Be Repaired?
Youn S. Kim, MD, Chief of Thoracic and Cardiovascular Surgery, Blodgett Memorial Medical Center, Grand Rapids
"Tingling Fingers — Is It Thoracic Outlet Syndrome?"

☐ Current Concepts in Systemic Diseases and the Macula

PRESENTED BY: Michigan Ophthalmological Society

This course, designed for ophthalmologists and non-ophthalmic physicians, will review current thought on macular involvement in hypertension, arterial occlusive disease, diabetes mellitus, vein occlusion, and certain infectious diseases. Evaluation of vision in young children will be included. Upon completion of this course, the hysician should be acquainted with current concepts in e diagnosis and management of the macular conditions iscussed.

OURSE DIRECTOR: Richard Lewis, MD, Ann Arbor

RESIDING: Doctor Lewis

PEAKERS:

ee Jampol, MD, Assistant Professor of Ophthalmology, linois Eye and Ear Infirmary, Chicago
obert Frank, MD, Assistant Professor of Ophthalmology, resge Eye Institute, Detroit
oward Joondeph, MD, Associate Ophthalmologist, De- oit Institute of Ophthalmology and Consultant in Retina, enry Ford Hospital, Detroit
ichard Lewis, MD, Assistant Professor of Ophthalmology, niversity of Michigan Medical School

☐ Diagnosis and Treatment of Cardiac Arrhythmias

RESENTED BY: Department of Medicine, Wayne State niversity School of Medicine

his course will provide practical information and a gen- ral approach to patients with sick sinus syndrome, various chy-arrhythmias, and cardiac conduction problems, in- luding discussion of specific diagnostic electrocardio- raphic techniques. Case problems will be included for dis- ussion.

OURSE DIRECTOR: Franklin E. Hull, MD, Detroit

RESIDING: Doctor Hull

PEAKERS/SUBJECTS:

unilendu Ganguly, MD, Associate Professor of Medicine, ayne State University School of Medicine and Director, ection of Cardiology, Hutzel Hospital, Detroit
"Sick Sinus Syndrome"
rederick Talmers, MD, Professor of Medicine, Wayne tate University School of Medicine and Director, Section f Cardiology, Veteran's Administration Hospital, Allen ark
"Cardiac Tachy-Arrhythmias"
opal Das, MD, Associate Professor of Medicine, Wayne tate University School of Medicine and Director, emodynamics Laboratory, Veteran's Administration ospital, Allen Park
"Cardiac Conduction Problems"
ranklin E. Hull, MD, Director of Cardiology Division and rofessor of Medicine, Wayne State University School of edicine and Director, Section of Cardiology, Harper- race Hospital
"Case Illustrations"

☐ Medical Genetics for the Practicing Physician

RESENTED BY: Departments of Internal Medicine and uman Genetics, University of Michigan Medical School

his course will instruct practicing physicians to apply imple genetic principles in the diagnosis, management and revention of illness. Case studies will illustrate the role of ereditary factors in common diseases and new techniques of basic diagnosis, screening, prenatal diagnosis and genetic counseling. Major emphasis will be placed on the role of the physician in the prevention and management of common hereditary diseases.

COURSE DIRECTOR: Thomas D. Gelehrter, MD, Ann Arbor

PRESIDING: Doctor Gelehrter

SPEAKERS/SUBJECTS:

Thomas D. Gelehrter, MD, Professor of Internal Medicine and Human Genetics and Director, Division of Medical Genetics, University of Michigan Medical School
"How to Take a Family History and Why"
"Genetic Counseling"
Robert P. Erickson, MD, Associate Professor of Human Genetics and Pediatrics, University of Michigan Medical School
"Genetic Screening and Prenatal Diagnosis"
"Evaluation of Congenital Defects and Mental Retardation"

☐ Panoramic View of Marital Therapy

PRESENTED BY: Michigan Psychiatric Society

Lectures, slide presentations, videotape and discussion will be utilized in this course to teach psychiatrists and primary care physicians to be capable of evaluating and diagnosing marital problems and formulating a therapeutic approach to return disharmony to a normal state of marital homeostasis. The Normal Value System for Treatment of Marital Disharmony will be used.

COURSE DIRECTOR: Peter A. Martin, MD, Southfield

PRESIDING: Doctor Martin

SPEAKERS/SUBJECTS:

Peter A. Martin, MD, Southfield, Clinical Professor of Psychiatry, University of Michigan Medical School and Wayne State University School of Medicine
"What is Marital Therapy"
"Normal Value System for Treatment of Marital Problems"
Muriel Tornga, ACSW, Ann Arbor, Executive Director, Marital and Family Therapy Clinic, Department of Psychiatry, University of Michigan Medical School
"The Utilization of a Female Co-Therapist in Marital Therapy"
John G. Howells, MD, Family Therapist visiting from England
"Family Therapy in Great Britain"

☐ Ultrasonic Imaging in Radiology

PRESENTED BY: Michigan Radiological Society

COURSE DESCRIPTION: Ultrasonic Diagnosis is now used routinely in the investigation of many diseases. In the past five to ten years there has been an enormous increase in the number of procedures provided as well as in the number of trained physicians and instruments available.

Indications and capabilities of these techniques for various organ systems will be presented.

COURSE DIRECTOR: Kenneth L. Krabbenhoft, MD, Director of Divisions of Neuroradiology and Diagnostic Ultrasound, Detroit

PRESIDING: Doctor Krabbenhoft

SPEAKERS/SUBJECTS:

Paul B. Wollschlaeger, MD, Professor of Radiology, Director of Divisions of Neuroradiology and Diagnostic Ultrasound, Wayne State University School of Medicine, Detroit
"The Role of Ultrasound in Radiological Diagnosis"

Terry M. Silver, MD, Associate Professor of Radiology; Director, Section on Ultrasound, Department of Radiology, University of Michigan Medical School, Ann Arbor.
"Abdominal Ultrasound"

Barry I. Samuels, MD, Associate Professor of Radiology, Wayne State University School of Medicine, Detroit
"Retroperitoneal Ultrasound"

William B. Steel, MD, Chief, Division of Diagnostic Ultrasound, Department of Radiology, Hutzel Hospital, Detroit
"Gynecologic and Obstetric Ultrasound"

James Karo, MD, Director, Division of Diagnostic Ultrasound, Department of Nuclear Radiology, Providence Hospital, Southfield
"Echocardiography"

☐ What's New in Acid-Base and Fluid-Electroly Balance

PRESENTED BY: Division of Nephrology, Wayne Sta University School of Medicine

Through lectures and detailed outlines, the primary phy cian will initially review the pertinent physiology needed *understand* fluid and electrolyte disorders. Using hypon remia and acid-base disorders, an up-to-date review common clinical problems leading to these disorders a methods by which to differentiate the common causes w then be discussed. Also, useful physiologic oriented tre ment regimes will be given.

COURSE DIRECTOR: Franklin McDonald, MD, Detroit

PRESIDING: Doctor McDonald

SPEAKERS/SUBJECTS:

Franklin D. McDonald, MD, Professor of Medicine and I rector of Nephrology, Wayne State University School Medicine
"Physiology of Filtration, Concentration, Dilution a Sodium Excretion"

Saadi M. Taher, MD, Assistant Professor of Medicin Wayne State University School of Medicine
"Physiology of Acid, Bases, Buffers, Renal and Pulm nary Control of Acids and Bases"

Pravit Cadnapaphornchai, MD, Associate Professor Medicine, Wayne State University School of Medicine a Chief of Nephrology, Detroit General Hospital
"Hyponatremia: Differential Diagnosis and Treatment

Stephen D. Migdal, MD, Assistant Professor of Medicin Wayne State University School of Medicine
"Acidosis: Differential Diagnosis and Treatment"

William A. Briggs, MD, Associate Professor of Medicin Wayne State University School of Medicine and Chief Nephrology, Harper Hospital
"Alkalosis: Differential Diagnosis and Treatment"

Special Nov. 7-8-9 Activities Other Than Courses

MICHIGAN ALLERGY SOCIETY: Wednesday, November 8; 10:00 am business meeting

MICHIGAN ASSOCIATION OF NEUROSURGEONS: Wednesday evening, November 8; reception and dinner

MICHIGAN OPHTHALMOLOGICAL SOCIETY: Thursday, November 9; 10:00 am business meeting, evening reception and dinner

***MICHIGAN ORTHOPAEDIC SOCIETY:** Wednesday evening, November 8; reception and dinner

MICHIGAN OTO-LARYNGOLOGICAL SOCIETY: Wednesday, November 8; 1:00 pm business meeting, evening reception and dinner

MICHIGAN PSYCHIATRIC SOCIETY: Thursday, November 9; 10:00 am Council meeting

MICHIGAN RADIOLOGICAL SOCIETY: Thursday evening, November 9; 6:00 pm reception, 7:00 pm dinner

MICHIGAN SOCIETY OF COLON AND RECTAL SURGEONS: Wednesday evening, November 8; reception and dinner

MICHIGAN SOCIETY OF OBSTETRICIANS AN GYNECOLOGISTS: Wednesday, November 8; 10:00 a business meeting

MSMS COMMITTEE ON IMPAIRED PHYSICIAN Tuesday, November 7; 6:30 reception and dinner

MICHIGAN STATE PHYSIATRIC SOCIETY: Tuesda November 7; 6:30 reception and 7:30 dinner

MICHIGAN UROLOGICAL SOCIETY: Wednesday, N vember 8; 6:00 pm reception; 7:00 pm dinner

WAYNE COUNTY MEDICAL SOCIETY BEAUMON LECTURE: Tuesday, November 7; 6:30 reception and di ner, lecture by Howard M. Spiro, MD, Yale University, "Current Trends in Gastroenterology." For dinner ticke please contact Wayne County Medical Society, 1010 A tietam, Detroit 48207. All MSMS members are invited the dinner, or to the lecture which will provide one hour Category I credit.

WAYNE STATE UNIVERSITY MEDICAL ALUMN Wednesday, November 8; 6:30-8:00 pm reception

*indicates tentative scheduled activities

PLEASE SEND ENTIRE PAGE WITH CHECK

1978 Michigan State Medical Society Annual Scientific Meeting Registration Form for Category I CME Courses

* Courses Approved for Prescribed Credit by the American Academy of Family Physicians

TUESDAY MORNING, NOV. 7

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Basic Cardiac Life Support
*_____ Common Pitfalls in the Management of Malignancies
*_____ It's Now Easy to Recognize & Manage Chronic Obstructive Pulmonary Disease
*_____ Management of Diabetes Mellitus — Problems in Acute and Chronic Care
*_____ Newer Developments in the Evaluation and Treatment of the Hypertensive Patient
_____ Sex and the Heart Patient
*_____ What's New and Practical in Peripheral Vascular Surgery

TUESDAY AFTERNOON, NOV. 7

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alcohol and Medical Practice
*_____ Assessment and Management of the Patient with Acute and Chronic Renal Failure
*_____ Care in the September Years
_____ Current Trends in Coronary Artery Bypass Graft Surgery
*_____ Sexuality: New Recognition Or Another Perspective of an Old Subject
*_____ What's New and Practical in Office Endocrinology
*_____ What's New in Anti-Arthritics, Beta-Blockers, Bronchodilators, Vasodilators — With Special Attention to New Agents & Drug Interactions

On Tuesday evening, Wayne County Medical Society will present its Annual Beaumont Lecture at a dinner program. Write to WCMS, 1010 Antietam, Detroit 48207 for details about program and registration.

The courses will provide 3 hours of Category I credit toward the state relicensure requirements and the AMA Physicians Recognition Award.

Please check the courses you wish to attend. In each case please indicate a second choice should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, luncheon tickets, etc., must be picked up at the MSMS Registration Desk upon arrival at the Detroit Plaza.

Physicians must make their own hotel reservations prior to 10/16/78 direct with the Detroit Plaza Hotel, Renaissance Center, Detroit, MI 48243. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Scientific Meeting.

WEDNESDAY MORNING, NOV. 8

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Advanced Cardiac Life Support (A 16-hour course to run all day Nov. 8 and 9. (See tuition below)
*_____ Common Errors in Pediatric Management
*_____ Diagnosis & Treatment of Common Esophageal Disorders
*_____ Diagnosis & Treatment of Patients with Hematologic Disorders
*_____ Diagnosis & Treatment of Pneumonia and Legionnaires' Disease
*_____ Evaluation of the Dizzy Patient for the Family Physician
_____ Lead Poisoning — An Update
*_____ New Concepts in Peptic Ulcer Disease / New Approaches to Obstructive Jaundice
_____ Newer Developments in Diagnosis and Treatment of Neurological Problems
*_____ Office Dermatology for the Non-Dermatologist
*_____ Office Gynecology for Non-Gynecologists
*_____ What's New in Surgery

WEDNESDAY AFTERNOON, NOV. 8

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Congestive Heart Failure — New Concepts in Evaluation and Therapy
*_____ Cost Awareness and Medical Care
*_____ Current Concepts and Management of Common Pediatric Surgical Problems
_____ Current Management of Hemorrhoids, Anal Fissures and Anal Fistulas
_____ Cutaneous Manifestations of Systemic Disease
*_____ Dealing with Women Patients
*_____ Diagnosis and Treatment of Allergy and Bronchial Asthma in Children
*_____ Diagnosis and Treatment of Common Rheumatic Disorders
_____ Identification and Management of the High-Risk Obstetrical Patient
*_____ Male Sexual Problems: Impotency, Infertility
*_____ Nuclear Medicine — Review of Current Applications and New Developments
*_____ Physicians and Their Families
*_____ Poisonings in the Emergency Department

THURSDAY MORNING, NOV. 9

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Diagnosis and Treatment of Common Athletic Injuries
*_____ Diuretic Therapy: Applications and Complications
*_____ Exercise in Medicine: Controversies, Indications, Proper Prescribing, and Precautions
*_____ Frequent Problems in ECG Interpretation
_____ Immunology and Inflammatory Bowel Disease
_____ Interpreting the Biochemical Profile
_____ Nosocomial Infections: Recognition and Management
*_____ Role of Hyperalimentation in Common Medical and Surgical Disorders
_____ Scientific Medical Writing
_____ Transplantation: Current Status and Future Prospects

THURSDAY AFTERNOON, NOV. 9

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Antibiotic Therapy — New Advances
*_____ Chronic, Non-Alcoholic Liver Disease
_____ Common Problems in Thoracic Surgery
*_____ Current Concepts in Systemic Diseases and the Macula
*_____ Diagnosis and Treatment of Cardiac Arrhythmias
*_____ Medical Genetics for the Practicing Physician
*_____ Panoramic View of Marital Therapy
_____ Ultrasonic Imaging in Radiology
*_____ What's New in Acid-Base and Fluid-Electrolyte Balance

Name (please print) ____
(last) (first) (initial)
Street ____
City ______________________ State ________ Zip ________

Please check one of the below:

_____ MSMS member _____ Non-MSMS member _____ Resident in training

Tuition schedule for courses:
MSMS members: $4 per credit hour, or $12 for each half-day course
Non-MSMS members: $8 per credit hour, or $24 for each half-day course
Residents and Interns: No charge

Luncheon reservations: The hotel will provide a luncheon each noon at $7 per person. Advance reservations are requested so MSMS can give the Detroit Plaza an accurate guarantee. Please indicate which days you want luncheon.

Tuesday lunch _____ Wednesday lunch _____ Thursday lunch _____

- Indicate total number of half-day courses_____ × $12 (or $24) = $ _____
- Number of luncheons requested _____ × $7 = $ _____
- Registration for special 16-hour ACLS Course ($115 incl. lunch) $ _____
- Total amount due MSMS $ _____

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823

57 COURSES OFFER 3 HOURS OF CATEGORY I CREDIT

Special Advanced CLS Course Offered Nov. 8-9

For the first time, MSMS and the Michigan Heart Association will offer to physicians at the MSMS Annual Scientific Meeting the complete Advanced Cardiac Life Support Course. The 16-hour course will run eight hours on Wednesday, November 8, and the final eight on Thursday, November 9.

The project will be directed by Daniel T. Anbe, MD, director of cardiac rehabilitation in the Ford Hospital division of cardiovascular medicine.

"The course will be limited to 40 physicians who have completed the CPR course," explains Doctor Anbe. The MSMS Annual Scientific Meeting in 1976 and in 1977 offered the CPR course several times. A three-hour CPR course will be offered Tuesday morning, November 7 for anyone who might want to then complete the advanced course on Wednesday and Thursday.

Many Michigan physicians have completed the basic CPR course in their local hospitals or at the 1976 and 1977 MSMS meetings.

Physicians must register for the 16-hour approved course before Oct. 10. They will be sent an extensive packet of study materials and instructions. The American Heart Association ACLS texts will be followed. Candidates who successfully complete the testing according to AHA standards will be certified as providers in ACLS by the Michigan Heart Association, explains Doctor Anbe.

The registration form for the Scientific Meeting includes the opportunity for this advanced course. A fee will be charged to cover the costs of study materials, materials for use at the course, and for a special faculty of 13 trained instructors.

Advance registrations are required so materials can be sent for study prior to the full two-day course.

Doctor Anbe, the course director, also is a member of the national ACLS faculty.

Select Courses of Practical Value; Enroll Today . . . Take Your Choice . . .

7 Courses, Tuesday Morning, Nov. 7 — See Pages 2-3
7 Courses, Tuesday Afternoon, Nov. 7 — See Pages 4-5
12 Courses, Wednesday Morning, Nov. 8 — See Pages 6-8
13 Courses, Wednesday Afternoon, Nov. 8 — See Pages 9-12
10 Courses, Thursday Morning, Nov. 9 — See Pages 13-15
9 Courses, Thursday Afternoon, Nov. 9 — See Pages 16-18
Registration Form — See Page 19

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Vol. 77 No. 25, September 11, 1978

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Managing Editor: Judith Marr

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Michigan Medicine

PTEMBER 1978 • VOLUME 77, NUMBER 26
URNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

ANNUAL
SCIENTIFIC MEETING
NOV. 7-8-9

MSMS Annual Scientific Meeting Registration Form appears on page 530 of this issue.

Meeting Chairman Wilson, CME Programming Committee Chairman Hammerstrom and Council Chairman Zako confer on details at the Detroit Plaza, site for the 1978 MSMS Annual Scientific Meeting Nov. 7-8-9.

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Contents

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

With the Detroit Plaza Hotel and Renaissance Center in the background, MSMS leaders urge Michigan physicians to attend the 1978 MSMS Annual Scientific Meeting Nov. 7-8-9. You may register using the form on page 530 of this issue.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

Special section

473 The courses, course directors, the hotel, the city all are profiled in special sections in front and back of this issue devoted to the 1978 MSMS Annual Scientific Meeting. The final page has the registration form. Mark your calendar and plan to attend!

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ANNUAL SCIENTIFIC MEETING NOV. 7-8-9

Scientific Meeting leaders urge attendance Nov. 7-8-9

"The 100 physicians involved in planning the 1978 Annual Scientific Meeting are enthusiastic about urging physicians to enroll in their courses at the Detroit Plaza, Nov. 7-8-9. I wish each of them could have space in *Michigan Medicine*, but that is not possible."

That comment is made by Carl F. Hammerstrom, MD, Marquette, chairman for the MSMS Committee for CME Programming, which is responsible for the Category I aspects of the meeting.

Updating the key

Why should physicians attend ASM courses? "A Michigan physician should attend to further his or her education — especially for 'updating.' Courses always provide suggestions about new methods, new products, etc. New information always helps a physician discuss medical concerns with patients." So states Frederick W. Bryant, MD, member of MSMS Council from the Oakland-Macomb councilor district.

"Information at my course will give the physician the opportunity to learn in a condensed manner about some new and exciting developments in the discipline of surgery," points out Dan C. English, MD, head of the Department of Surgery at Michigan State University, who will conduct a course Wednesday morning, Nov. 8.

"Medical school curricula, in my opinion, do not deal adequately with sexual problems, so my course will offer helpful information for the primary physician," explains Gerald W. Conway, MD, Royal Oak, who will present a course Wednesday afternoon, Nov. 8 on "Male Sexual Problems: Impotency, Infertility." "A greater knowledge of current medical, psychological and surgical therapies will enable the physician to confidently evaluate men with sexual problems and then to treat or refer these men," he adds.

"Physicians should attend the course in 'Congestive Heart Failure' because there has been a profound change in the approach to patients with congestive heart failure over the past two years," stresses Bertram Pitt, MD, University Hospital, Ann Arbor, who will offer his course Wednesday afternoon, Nov. 8. "We will deal with diagnostic approaches to the patient with heart failure, use of new vasodilators and inotropic agents, and prognostic indicators."

"Our course should allow doctors with different points of view about potential lead poisonings to discuss together this subject of mutual interest," declares William L. Knapp, MD, of the Chrysler Corporation, Highland Park. "We will try to make the physician more aware of the extent and nature of lead exposure by and to his patients in their environment at work, at home and in leisure time." His course, "Lead Poisoning — An Update" will be Wednesday morning, Nov. 8.

Depart from routine

David Hawtof, MD, of Southfield, a course director last year, encourages MSMS members to "get away from the routine — take a course in a different field."

"The course in 'Nuclear Medicine' will help the physician learn how easily significant diagnostic information can be obtained by non-invasive nuclear testing," states Daniel S. Marks, MD, Detroit, who will offer a course Wednesday, Nov. 8 in the afternoon. He points out, "There have been many important, new tests and techniques developed in the last few years which have simplified the acquisitions of physiological and pathological data."

MSMS members can review detailed information about the 1978 Annual Scientific Meeting courses by reading the September 11 issue of *Medigram*.

That *Medigram* includes course descriptions, lists of faculty members — along with a registration form. The form also appears on page 530 of this issue.

"Members should register now. Every year some of the courses fill quickly and physicians must then enroll in their second choice," explains Carl F. Hammerstrom, MD, chairman of the MSMS Committee for CME Programming.

Mark B. Orringer, MD, University of Michigan, explains that "every practicing physician encounters patients who have disorders of esophageal function, esophageal spasm or diverticula, gastroesophageal reflux or neoplasm. A knowledge of currently available diagnostic approaches in these patients is critical for initiation of appropriate therapy." He is the course director for "Diagnosis and Treatment of Common Esophageal Problems," Wednesday morning, Nov. 8.

"The physician attending this course in 'What's New in Acid-Base and Fluid-Electrolyte Balance' will take away an outline of the common entities leading to acid-base and sodium disorders, simple ways to distinguish among the possibilities in the differential diagnosis and physiologically sound methods of therapeutic approach to each of these problems," says Franklin D. McDonald, MD, Wayne State University College of Medicine. His course will be on Thursday afternoon, Nov. 9.

"Physicians participating in our course should be able to identify the most common sources of error in treating many of the common illnesses children present to the primary physician," suggests Ralph Cash, MD, Children's Hospital of Michigan. He will offer "Common Errors in Pediatric Management" Wednesday morning, Nov. 8.

Robert F. Wilson, MD
Scientific Meeting
chairman

Meet the course directors for MSMS Scientific Meeting

Aldridge

Anbe

Anderson

Arends

Barrett

Bedell

Bishop

Bole

Cash

Conway

Cotton

Danek

Dean

DeWitt

Downham

English

Fox

Gelehrter

Gilroy

Greenawald

Gulati

Henley

Hertzler

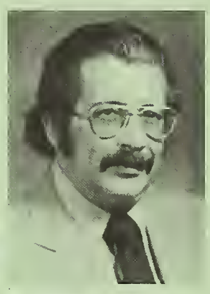
Hull

See Scientific Meeting Registration form on page 530.

Kauffman

Knapp

Krabbenhoft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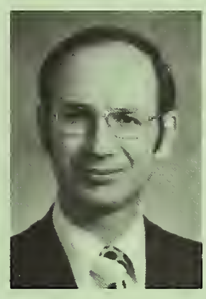
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Pitt

Rontal

Royer

Sklar

Smith

Stanley

Stransky

Tannen

Turcotte

Vaitkevicius

Weg

Wilcox

Zimont

(Photos of other directors were not available.)

Detroit Plaza biggest, most unusual Michigan hotel

By C. R. Shelton
***Special to* Michigan Medicine**

"A city in itself" is what many people call the Detroit Plaza Hotel.

Situated in the middle of the impressive Detroit Renaissance Center, the 73-story structure, which opened to guests March 15, 1977, is the world's tallest hotel and the highest building in Michigan.

The Western International-managed hotel features 1,400 "world class" guest rooms, including 104 suites, which rise above the lobby in a glass-enclosed tower. Decorated in warm earth tones, each room or suite offers a 180-degree view of the Detroit River, the city, or Canada.

As you would expect in such a luxurious setting, the hotel, which was designed by John Portman, has a year-around swimming pool, a health club, and 24-hour room service. Additionally, the Plaza boasts numerous restaurants and lounges, including The Summit — a revolving restaurant 740 feet above the Detroit River — and several elegant ballrooms.

As you enter the Plaza's eight-story atrium lobby, you may feel that you have arrived on another planet . . . one made of concrete, glass, water, and green plants. And you will not be far from correct, because the lobby walls are bare concrete, designed artistically. The lobby contains a half-acre reflecting pool, over 720 mum plantings, 5,000 grape ivy plants, 3,000 philodendrons, 189 weeping fig trees, and 33 kentia palm trees.

Motion and repose

The atrium lobby, with the myriad opportunities it provides for both privacy (cocktail pods give a feeling of enclosed intimacy) and people watching (sidewalk cafe dining, or lounging in seats along the reflecting pool), achieves an essential balance between the perpetual motion of a city and the human need for repose.

An elevator ride to The Summit is one of the highlights of a visit to The Detroit Plaza. Enclosed in glass cylinders, the two non-stop elevators run up the outside of the hotel and give a slow-motion (1,000 feet per minute) version of a rocket trip.

This lounge-restaurant is located on the hotel's 71st, 72nd, and 73rd floors and is the world's largest rooftop revolving dining facility. It offers a spectacular view from any one of its three levels. You can readily see Windsor, Canada and Lake Erie on the south, and, on a clear day, the Silverdome in Pontiac, 35 miles north.

After a trip to The Summit, you might think that you have "done The Plaza." But there is much more to explore. Other dining areas in the hotel include the fashionable gourmet La Fontaine; The Mikado, an authentic Japanese restaurant where kimono-clad Japanese servers prepare food at floor-level tables; Cafe Renaissance, a French-style sidewalk cafe; Coffee Garden, a family-type restaurant; Cafe Express, self-service buffet; and Celebration, a semicircular lounge where entertainment is continuous in the evening.

Also, there are Bagel Nosh, where everything is served on a bagel; Big Boy, hamburgers and the works, of course; House of Hong, Chinese dining; Koney Island Inn, need we say more?; Magic Pan, creperie; Nemo's Pub, a turn-of-the-century Irish Pub; Olga's Kitchen, Greek specialities; The Cookie Machine, serving freshly made cookies and confections; Tiffany Bakery, the ultimate in baked goods; and, of all things, McDonald's — this one is similar in concept to McDonald's at the Embarcadero in San Francisco and the Water Tower in Chicago.

Shopping unlike anything

Shopping in the Renaissance Center (you will never know when you are out of the hotel itself and in Ren Cen) is an experience unlike anything in Michigan.

Some of the top international names in fashion have opened, or are opening, boutiques in the 350,000 square-foot "World of Shops" retail area.

These include Cartier, Courreges, Lanvin, Valentino and Halston. Other internationally-known shops are Godia Chocolatier, F.A.O. Schwarz Toys, and Leonard of London Beauty Salon.

The Detroit Plaza will offer MSMS members and spouses a discount rate for rooms. Physicians should reserve rooms direct, mentioning their attendance at the MSMS three-day meeting. Write Detroit Plaza, Renaissance Center, 48243.

More ASM stories pages 527-530

Doctor Zako testifies:

Second opinion issue not one for government mandates

The following thoughts about surgery and second surgical opinions were presented by Louis R. Zako, MD, chairman of The MSMS Council to the Michigan Insurance Commissioner during a recent hearing. Doctor Zako and MSMS President Louis E. Heideman, MD, developed an official statement covering various aspects of medical costs and quality care. Interested physicians may obtain a copy of the full statement by writing to the MSMS Department of Health Care Delivery, 120 West Saginaw, East Lansing, MI 48823.

"It is inherent that physicians are committed to doing only what is in their patients' best interest and therefore presumably necessary.

"A variety of review mechanisms have been utilized to verify that surgery was necessary and was appropriate, the most recent being PSROs, which haven't yet been given a chance to demonstrate what their potential is. Second surgical opinion is now presented as the protector of the innocent and the saviour of funds.

"MSMS has accepted the need for more careful and adequate studies of second surgical opinion without disavowing or endorsing it, but suggesting that appropriate scientific studies be conducted. Doctor Beverly Payne of Ann Arbor has developed such a study protocol which has fulfilled the criteria of MSMS. His support data includes a most interesting calculation purporting to demonstrate that we can project a 16 percent difference in opinion between any two surgeons. This is based on the assumption that a surgeon has a probability of recommending a specific surgical procedure in a given situation of .80. This projects to a 16 percent disagreement between any two surgeons, increasing with the addition of other consultants.

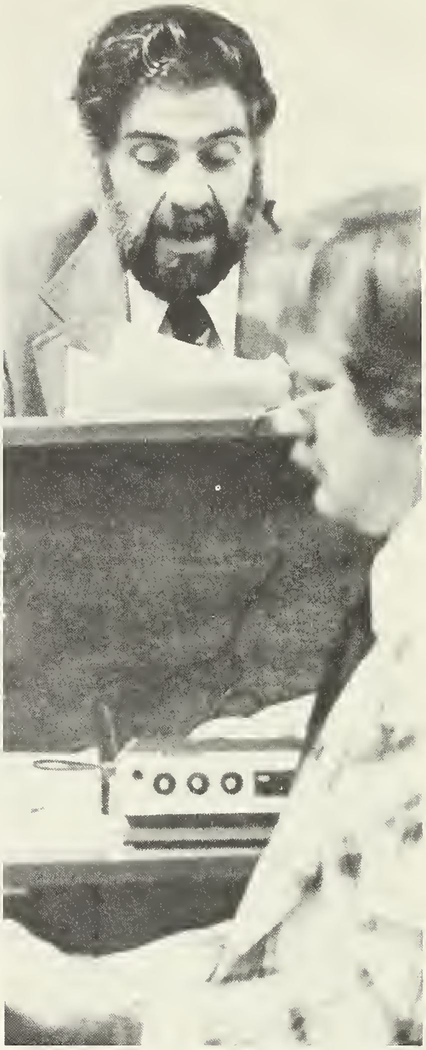
"One of the things that is often forgotten when non-physicians discuss second opinions is that most patients do not go directly to the surgeon. They are seen by another practitioner who may make a specific diagnosis, recommend surgery and offer a number of surgeons for the patient to choose from. Or a surgical condition may be suspected and a referral made for consultation.

"An interesting corollary to any study of second opinions would be the frequency with which surgeons refuse to operate. They are fully aware of the risks inherent in each operation, of the risks of complications, and also of the risks of not doing surgery.

"Tonsillectomy, hysterectomy, herniorrhaphy, cholecystectomy, and resection of the intervertebral disc are the conditions currently under attack. Each of these has the potential of emerging as an acute emergency, necessitating surgery when the patient is in less than optimal condition, with the attendant increase in hazard to the patient.

"We are not condoning unneeded surgery. We are saying that the definition of 'medically necessary surgery' involves much more than the concurrence in judgment between any two surgeons. Because many areas of medicine are not governed by precise rules there is a possibility that a diagnosis remains obscure or in doubt regardless of the number of consultations.

"In addition we believe that the issue of second opinions or additional consultations is a matter between the physician and the patient. It is not a matter of hospital management or governmental mandate, and it is inappropriately included in the rules."



Doctor Zako as he testified before the Michigan Insurance Bureau.

Anxiety...
Often a significant feature
of irritable bowel syndrome*

The action of
Librium
(chlordiazepoxide HCl)

A significant advantage
of adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

Antianxiety
Antisecretory
Antispasmodic

Librax is unique among medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy in irritable bowel syndrome* and duodenal ulcer.

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on following page.

ROCHE

Librax®
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701

1933 warning to medicine: "Independence at Stake"

Whether the medical profession of Michigan will assume leadership and solve its own problems or whether you will permit conditions to develop that will cause others, outside the profession, to solve them for you rests solely with you who represent your fellow members.

Your honor, dignity and independence are involved.

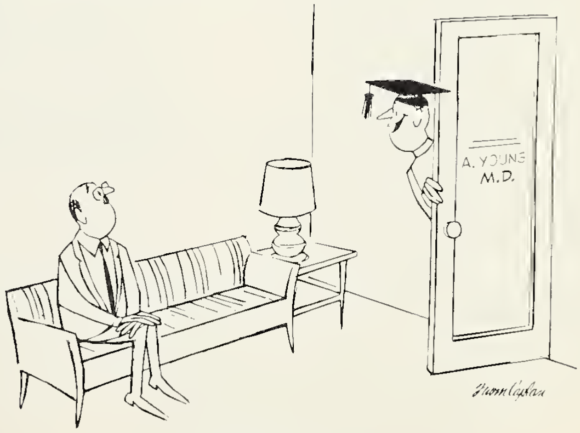
There are before you examples of movements with many ramifications that threaten the profession's future.

Will you fail to recognize them until the entering wedge has been driven in so deeply that its removal will be difficult and may cost heavily?

Medicine is in a strategic position. A controlled offensive will retain the advantage now held and hold the strongholds you now revere. Medicine in its scientific and economic practices must keep pace with the body politic to retain its independence.

Only by a united profession devoted to a common cause can we continue to progress.

— Excerpts from address to MSMS House of Delegates, by Council Chairman B. R. Corbus, MD, November 1933



"Come in, sir!"

At a July seminar, MSMS described its project to improve health care delivery in county jails to several more facilities interested in upgrading their programs. Among those attending were Capt. Carl Matheny, Oakland County jail administrator; Philip Heffron, Kent County sheriff, and Lt. Jack Spaulding, Genesee County jail administrator, from left above.

MSMS Jail Health Care Project Director Herbert Mehler, standing, reviewed fine points of the large manual distributed to seminar participants. The manual contained all 42 recommendations for earning AMA jail health care accreditation. From left, seated, are Stewart Weiner, Genesee County Health Department; James Frank, Ingham County jail administrator, and Bonnie Samuelson, Ingham County jail nurse.

Michigan Medicine photo page

The inscription on the plaque reads, "Medical Journalism Award, First Prize, presented by Sandoz Pharmaceuticals to *Michigan Medicine* for excellence in design and editorial content." Sharing the presentation during the Midsummer Meeting of the MSMS Council are, front row from left, William Loughran, associate for medical sciences liaison with Sandoz; Judith Marr, managing editor; James H. Tisdel, MD, Port Huron, Council vice chairman and chairman of the Committee on Publications, and Herbert A. Auer, executive editor. Back row from left are Publications Committee members Harvey M. Andre, MD, Grand Rapids; Busharat Ahmad, MD, Marquette; S. A. Yannitelli, MD, Battle Creek, and Charles L. Oppy, MD, Roscommon. Not pictured is committee member James D. Fryfogle, MD, Detroit.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When
impotence
is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

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2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Meet Louis E. Heideman, MD, MSMS president

By Judith Marr
Managing Editor

"This is one of those areas where nobody has enough resources. They keep pushing kids around."

Louis E. Heideman, MD, made the comment half to himself, his thoughts busy with how to solve the problems before him. There was a tinge of exasperation in his voice.

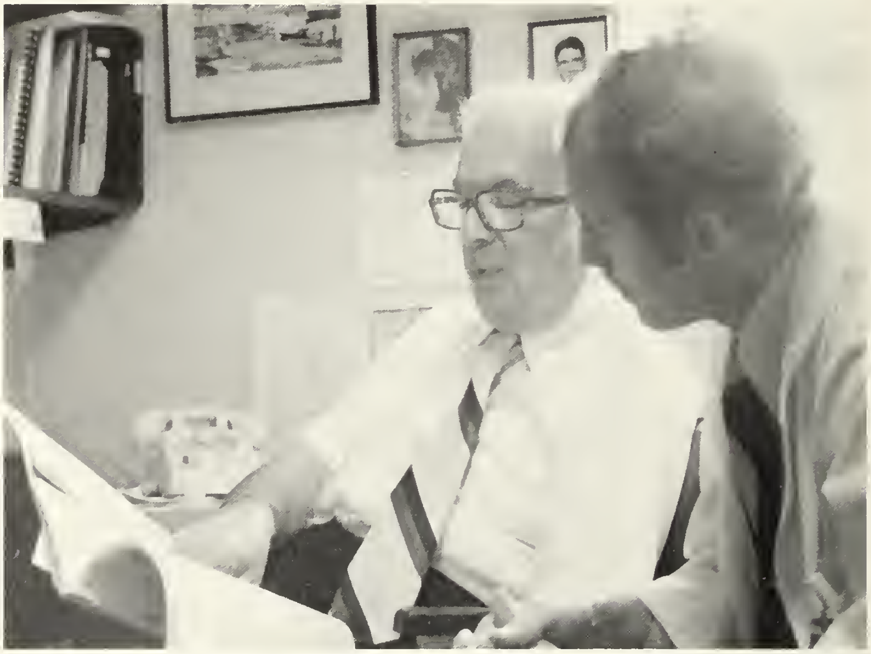
Across the corner of the desk from Doctor Heideman, who is the current president of MSMS, was a middle-aged black woman, mother of two of Doctor Heideman's newest patients, a teen-aged boy and girl.

The mother was describing her son Rowland's general good health and her worries that Rowland is slow and has some loss of hearing. Daughter Bernitta was in the doctor's office for an annual physical.

At sight of Doctor Heideman's tall, white-headed figure coming down the hall, Bernitta had earlier confided to the few persons in the tiny waiting room, "I've got butterflies."

Those who heard her remarks included Maryellen Losey, Doctor Heideman's secretary in the small, utilitarian office suite in the Couzens Memorial Building on St. Antoine in downtown Detroit, adjacent to the Detroit Medical Center. There also were the other members of Bernitta's family and a third-year Wayne State University medical student with pediatrics high on his list of specialty choices.

Since 1973, Doctor Heideman had been director of Adolescent Ambulatory Services with the Children's Hospital of Michigan. He was director of the department of pediatrics at Detroit General Hospital from 1971 to 1973. Doctor Heideman also is associate professor of pediatrics with the WSU School of Medicine.



Medical records help Doctor Heideman explain adolescent practice to WSU medical student Stephen Heinz.

"I find the adolescents fun to work with," Doctor Heideman confided to Stephen Heinz, the third-year medical student. Stephen is one of a succession of students who spend two weeks each with Doctor Heideman during their rotating clinical experiences.

"There is much confusion among us over adolescence, because we think of it as though it's a single, unified period," he said. "That isn't so. Adolescents have certain definite tasks to accomplish, definite skills to develop. They have to make certain adaptations in their perception of themselves and many adjustments in relationships take place at this time."

His comments were part of a detailed, sensitive description of the psychological-social and physical exams he gives his patients. Bernitta's "butterfly" feelings were well acknowledged and carefully managed during Doctor Heideman's dissertation to his current medical student.

Doctor Heideman and his wife Ethel are parents of a son, Michael Saul, 32, and daughter, Rosalind Diane, 30, and are the grandparents of two grandsons. The newest was born just four days after Doctor Heideman was installed as MSMS president May 6.

A photo of daughter Rosalind and son-in-law Louis P. Rochkind on their wedding day hangs on the wall above Doctor Heideman's desk.

This brief look into Doctor Heideman's practice of adolescent medicine, in which he sees about 1,000 children a year, reveals a side of the MSMS president perhaps not so well known to other MSMS members.

(Continued on page 484)

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DOCTOR HEIDEMAN/*continued*

Doctor Heideman gently questions a new patient in his Detroit pediatric practice.

They are well aware of his service the past year as MSMS president-elect, and before that as president of the Wayne County Medical Society. He was recent chairman of the MSMS Continuing Medical Education Committee and was an MSMS Council member from 1973-1976.

A graduate of the University of Michigan Medical School, Doctor Heideman was in private practice from 1946-1967, then became associate and executive director of Project Prescad in the Detroit area.

He is a corporate member of Michigan Blue Cross/Blue Shield and member of the Metro Health Plan Board.

Doctor Heideman has been active in many community and religious organizations and currently is serving on the Michigan Task Force on Medicaid and Health Care Costs.

During his year as MSMS president he plans to work on two of his principle interests — attempting to understand, evaluate and help form a program on health care cost control, and development of health education materials.

"I feel this is an area of increasing importance," he says of the latter. "It's significant in the area of cost control, but also to help our colleagues and people in general function more effectively.

"A lot of what is published seems to promote hypochondriasis. I would rather see the materials promote health. The emphasis on illness scares the daylights out of people.

"We must do something more constructive."

As for personal things, Doctor Heideman says he has "an interest in photography I don't work too hard at," and likes to see things grow.

"Of course, that's inherent in a pediatrician," he says. "We like to see children and other living things grow."

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®

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Division of Bristol-Myers Company
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IN THE DETROIT AREA, STAPH RESISTANCE HAS NOW REACHED 85%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

TEGOPEN®

(cloxacillin sodium)

..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.

- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.

Please see brief summary for prescribing information.

ANCEF®
brand of sterile
CEFAZOLIN SODIUM
GETS TO THE SITE

**OF SERIOUS
RESPIRATORY INFECTIONS**

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported: Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. Blood: Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred. Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Gastrointestinal: Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported. Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline &French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

Letters

'Minors may give own consent; no physicians liable for their care'

I am writing you in hopes of correcting erroneous impressions Michigan physicians may have gained upon the receipt of the July 19, 1978 issue of *Michigan Medicine.*

The information to be found under a subject heading of *Liability* on page 365, subtitled, "Here are Michigan Laws Regarding Treatment of Minors in Regular, Emergency Cases," presents an erroneous concept of the current liability situation in Michigan.

The initial paragraph begins with these words: "Physicians who treat minors without parental consent have been sued for assault, technical battery and even abridgment of property rights . . . Even when the care is appropriate, you can be sued if you fail to obtain the parents' permission."

While the possibility of attempted suits for assault and battery under these conditions is *possible,* there has never been a successful suit against a physician either in Michigan or anywhere in the United States for providing medical contraceptive services to minors without parental consent.

At a session entitled, "Legal Update," presented by Development Associates of Washington, D.C., on Monday, July 17, 1978 at the Radisson Cadillac Hotel in Detroit, comments were made on this subject by the foremost authority on the relationships between medical care, teenagers and the law. Ms. Harriet Pilpel, General Counsel for the National Planned Parenthood Federation of America, Inc., indicated that in all her research in case law, she could find no instance of any award for damages or any adverse judgments in cases where physicians provided contraceptive services to minors without parental consent where the minor is judged competent to give such consent, ie., a mature minor.

The second paragraph of the *Michigan Medicine* article correctly defines a minor as a person under age 18, but then erroneously goes on to claim that "medical treatment of minors requires consent of parent or guardian except in emergency."

In the most recent of surveys made periodically to update the current practices relative to informed consent, Ms. Pilpel , in a recent compilation, lists Michigan as a state in which minors may consent for medical care, in general, with no limitations as to age (if mature enough to understand the nature and consequences of such treatment); such minors in Michigan may also consent for medical care, in general, if married, or emancipated and in emergencies.

Michigan minors of *any age* may also give consent for contraception, pregnancy related care, venereal disease care and abortion (again, if mature enough to understand the nature and consequences of such treatment); the venereal disease care component as well as drug abuse problems for minors have, for several years, been independently covered by a separate, permissive state law which provides for the required treatment without parental consent. This rule of the "mature minor" is exemplified in the decisions of Bakker versus Welsh, Bishop versus Shurly and Zoski versus Gaines, respectively dated 1906, 1925 and 1935.

In the fourth paragraph, the article asserts, "a child under the statutory age is not likely to have, at law, sufficient mental capacity or independence from her parents to give a valid consent. Moreover, when the parents discover the child has been given the pill, they could involve the doctor on a charge of contributing to the delinquency of a minor."

Any physician's anxiety about the necessity of obtaining the consent of the parent or guardian before providing any kind of medical treatment for a minor, stems chiefly from the old, unwritten common law principles which have been superseded by the widespread adoption of what has come to be known as the "*Mature Minor Doctrine.*"

This means that before any patient can make a decision about or consent to medical treatment, he or she is entitled to a full explanation of the nature of the proposed treatment, its risks, its limitations and its alternatives; a minor can give valid, informed consent when it can be documented that he or she is sufficiently intelligent and mature to understand these explanations and implications. Several recent U.S. Supreme Court decisions have affirmed the right of minor children to obtain an abortion, not only without parental consent, but in the face of strongly-voiced parental opposition and objection. A federal judge has been recently quoted as saying, "Many girls of childbearing age are undoubtedly sufficiently aware of the relevant considerations to use temporary contraceptives," and furthermore, they are legally competent, in his opinion, to use contraceptives.

There has not been found any law in the Michigan statutes which states that it shall be illegal or illicit for a physician to provide contraceptive services to minors in the absence of parental consent.

(Continued on page 490)

Pleased to see Blues' PAT guidelines adopted by MSMS group

I was pleased to see in the June issue of *Michigan Medicine* that the MSMS Task Force on Medical Care Costs had adopted the guidelines on preadmission testing developed in the fall of 1976 by Blue Cross and Blue Shield of Michigan and the Michigan Hospital Association. Perhaps this show of support on the part of MSMS will further encourage physicians to work with local hospital administrators in the development and operation of effective PAT programs.

Leesa J. Key
Ann Arbor

something you might have overlooked...

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Senior Advocates Council pleased with MSMS task force

We read with great interest about the formation of an MSMS Task Force to Improve Care of the Elderly. Health care emerged as a prime concern of the state's seniors in a grass-roots survey conducted by Michigan's 13 Area Agencies on Aging. More than 12,000 elderly who answered the survey viewed health care as an essential ingredient in their well-being, along with housing and transportation.

We would like to comment on Doctor Shipman's suggestion that medical students should acquire more clinical experience with the elderly, possibly in a nursing home setting. While these people undoubtedly need more consistent medical care, they represent only about five percent of the nation's elderly. The other 95 percent function in a community setting.

This group is more representative of the elderly that will comprise the doctor's patient load. She/he will have to perceive the varying levels of vitality and health of the elderly, which are just as diverse as other age groups.

Doctor Robert Butler, Director of the National Institute of Aging, has written at some length of the bias of the medical profession toward "ageism" — prejudice against the elderly as being unworthy of investment of time and effort." Part of this bias, according to Doctor Butler, is the limited exposure of medical students to any healthy elderly. "The older people emphasized in medical training are those with chronic disease, and cadavers," he points out in the March 1978 issue of *Hospital Practice*. He also states that "medical students are not exposed to healthy older people; no medical school rotates students through community senior centers, for example."

We hope that your task force will weigh carefully the concept of having medical students interact with varying groups of elderly, not only those in nursing homes. This could be an enriching experience both for the students and for the older people who often reflect the gift of a long, well-lived life.

We are very pleased to see that the Michigan State Medical Society has taken on the challenge of seeing the older patients as individuals, and discarding the stereotype of "senile" and "cranky" that sometimes hinders proper diagnosis and care of an important part of our population.

Edward Schnell, Chairperson
Michigan Senior Advocates Council
Lansing

TREATMENT OF MINORS/*continued*

Keeping in mind the various factors relative to obtaining valid, informed consent from mature minors, the statements and allegations of paragraph five labeled, "Married Minors," are totally incorrect. The article asserts that, "Before dispensing pills to married girls under 18, parental consent and the husband's consent prudently should be obtained." Can you imagine the outrage which would be enkindled in a young, married woman who is told that she must not only obtain her parent's consent but that of her husband prior to receiving contraceptive medications?

To sum up the correct, current legal positions in Michigan:

1. Minors of any age who are mature enough to understand the nature of and consequences of requested treatment, may give valid, informed consent on their own *without parental consent* for a wide variety of medical care including contraception, pregnancy related care, abortion, venereal disease and substance abuse.

2. There are no existing Michigan laws or statutes which make the giving of such care by physicians to mature minors an illegal or illicit act.

Charles J. Berger, MD, Medical Chief
Division of Maternal and Infant
Health, MDPH

P.S. I also would like to comment on the notice of the court case which was published on page 436, August *Michigan Medicine*. This case dealt with prescription of contraceptives to minors.

Physicians currently providing contraceptive (family planning) services to minors without parental consent or notification should be reassured that the recently reported decision by Judge Noel Fox of the Federal District Court in Grand Rapids has not changed the legal climate surrounding such service in any way or degree. Pending the resolution of an appeal process now before the Federal circuit court of appeal in Cincinnati, Judge Fox's decision has been effectively "stayed" and cannot be implemented; in other words his decision (requiring the *notification* of the parents of minors receiving contraceptive medical care without parental consent) has *not* been applied or effectuated and will not be implemented until the appeals process has been completed and/or his judgment overturned.

Congratulations to MSMS president-elect

Dear Doctor Griffin:

May I extend to you my personal congratulations and that of the American Medical Association on your election to President-Elect of the Michigan State Medical Society.

With the number and complexity of issues confronting physicians increasing almost daily, it is absolutely essential that we work together in solving our mutual problems.

If at any time the Association can be of assistance to you in this very important leadership position, please do not hesitate to call on us.

James H. Sammons, MD
AMA Executive Vice President

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MDPAC receives national leadership award

Thomas R. Berglund, MD, left, chairman of the Michigan Doctors Political Action Committee, was the pleased recipient of a Leadership Award from Rex Kenyon, MD, chairman, AMPAC board, during ceremonies at the recent AMA Annual Convention in St. Louis. Michigan received the honor because all of its AMA delegates and alternates, as well as the MSMS president and president-elect, are sustaining members of AMPAC and MDPAC. Sustaining members pay dues of $100, with half going to AMPAC and half to MDPAC. These personal contributions by physicians help support political candidates sympathetic to medicine's concerns for quality health care and its delivery. "It is vitally important for physicians to become aware and maintain their involvement in politics. So much of our profession is influenced by state and federal legislation and regulation, it is our responsibility to actively and financially support candidates who are responsible and understand the imperatives of quality health care."

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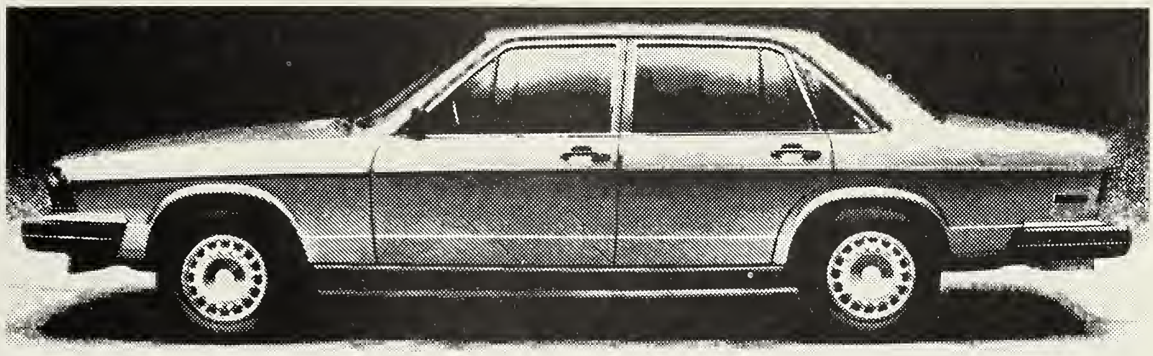

"I USED TO DESIGN RACING CARS. BUT THE AUDI 5000 WAS A BIGGER CHALLENGE."

AN INTERVIEW WITH FERDINAND PIËCH, AUDI 5000 PROJECT DIRECTOR

Sir, how long did you design racing cars?

Piëch: Ten years in all. I brought six cars from the drawing board to the race track and all six went on to win world championships. It was all very exciting.

And you say designing a passenger car was more of a challenge?

Piëch: It was for me. A racing car can be designed to last for a few races only. But a passenger car obviously has to be designed to do much more and to last much longer. In addition to excellent performance and handling I had to consider things like room, comfort and price.

What about the price?

Piëch: I was determined from the beginning to prove that a large German luxury sedan could be produced for under $9,000.*

Well, you succeeded with price, but did that mean you had to compromise a lot?

Piëch: No. I don't think so. It was a question of eliminating unnecessary things. The greatest example of that is our five-cylinder engine. Five cylinders, because a four was too small for the weight of the car, and a six was too extreme. Designing the perfect engine for the vehicle can hardly be called making a compromise.

Your racing background? Did it come in handy?

Piëch: Yes. Very much so. The way the Audi 5000 handles, for instance. The ride is not in the least bit mushy. Our suspension, rack-and-pinion steering and weight distribution have a lot to do with that. Some people feel that a soft, mushy ride is luxurious. We do not. We think it's tiring because you seem to be correcting the car's handling so often. That's why we suggest that people pick a rainy or snowy day for a test drive. This car is at its best when the weather is at its worst.

---

*Suggested 1978 retail price $8,780 P.O.E. transp., local taxes, and dealer delivery charges additional

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Category I courses

Date: Sept. 19-22, Blood Coagulation. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Medical Technologists, pathologists. **Cost:** $225/$175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 26½ hours of Category I Credit.

Date: Sept. 21-23, First Annual Human Development Seminar, "Solving Difficult Problems in Ambulatory Pediatrics: A Multidisciplinary Approach." Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** Michigan State University Department of Human Development in cooperation with Continuing Education Service. **For:** Primary care physicians in pediatrics. **Contact:** Conferences and Institutes, 50 Kellogg Center, MSU, East Lansing, MI 48824. **Approved for:** 16 hours of Category I Credit.

Date: Sept. 21, 22, 23. Implant Surgery for Joints and Tendons in the Hand. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Cost:** $200. **Contact:** Alfred B. Swanson, MD, Chairman, 290 Blodgett Professional Bldg., Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 23-24, Current Concepts of Respiratory Care. Location: Sugar Loaf Mountain. **Sponsor:** Michigan Society of Anesthesiologists and Wayne State University School of Medicine. **For:** Practicing anesthesiologists. **Cost:** $100. **Contact:** Wayne State University School of Medicine, Div. of CME, 540 E. Canfield, Detroit, 48201, 313/577-1180. **Approved for:** 9 hours of Category I Credit.

Date: Sept. 26, Symposium on Recent Advances in Cancer Care. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Grand Rapids Clinical Oncology Program. **Cost:** $50. **Contact:** Nancy Holleman, Continuing Medical Education, 616/774-1835. **Approved for:** 11 hours of Category I Credit.

Date: Sept. 27, "Will My Drinking Hurt My Baby?" A symposium on the Fetal Alcohol Syndrome. Location: Ann Arbor. **Sponsor:** University of Michigan Medical Center, Neuropsychiatric Institute. **For:** All specialties. **Cost:** $50. **Contact:** Suzanne Gilbert, G1109 Towsley Center for Postgraduate Medical Education, Ann Arbor, 48109, 313/763-0081. **Approved for:** 8½ hours of Category I Credit.

Date: Sept. 28, Scientific Symposium. Location: Towsley Center, U of M Medical Center. **Sponsor:** U-M Dept. of Pediatrics. **Cost:** $40. **Contact:** Doctor Oliver, 313/764-5173 or Doctor DeMoose, 313/764-8180. **Approved for:** 5¼ hours of Category I Credit.

Date: Sept. 28-29, Coping with Changes in the Later Years. Location: University of Michigan, Ann Arbor. **Sponsor:** U-M Institute of Gerontology. **For:** All specialties. **Contact:** Dorothy Coons, Director, CE Program, U. of Mich., 10G, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 29, 1978, Parenteral Nutrition. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, U of M Medical School. **For:** Surgeons, internists, family physicians. **Cost:** $40. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 30, 6th Annual Medical Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center/Northern Michigan Hospitals, Inc. **For:** Family physicians. **Cost:** $50. **Contact:** Lee R. Brunner, MD, Burns Clinic, 560 W. Mitchell St., Petoskey, 49770, 616/347-7000, ext. 500. **Approved for:** 6 hours of Category I Credit.

Date: Sept. 30, Michigan Society of Pathologists September Seminar, "Cardiovascular Diseases." Location: Sinai Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: Oct. 3, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 6, 7, 8, Annual Meeting, Michigan Chapter of the American College of Physicians. Location: Otsego Ski Club, Gaylord. **Sponsor:** Michigan Chapter, American College of Physicians. **Contact:** Boy Frame, MD, FACP, ACP Governor for Michigan, 543 Lakepointe, Grosse Pte. Park, 48230. **Approved for:** 12 hours of Category I Credit.

(Continued on page 496)

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CATEGORY I/*continued*

Date: Oct. 12-13, Infectious Diseases & Related Problems. Location: Kalamazoo Center Inn, Kalamazoo. **Sponsor:** Southwestern Michigan Academy of Family Practitioners. **Co-Sponsor:** SMAHEC Family Practice Residency. **For:** All specialties. **Cost:** $50. **Contact:** Donald E. DeWitt, MD, 436 Stryker Building, Borgess Hospital, 1521 Gull Road, Kalamazoo, 49001, 616/383-8395. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 12-13, Annual Clinical Conference. Location: Kalamazoo Hilton. **Sponsor:** American College Health Association, and Western Michigan University Continuing Education Department. **For:** All specialties. **Cost:** $15. **Contact:** Robert S. Gove, MD, 616/383-6025. **Approved for:** 5-7 hours of Category I credit.

Date: Oct. 15, "Dealing with Alcoholic Patients: Training for Primary Care Clinicians." Location: Traverse City. **Sponsor:** University of Michigan Medical Center, Neuropsychiatric Institute. **For:** Primary care physicians. **Cost:** $25. **Contact:** Michael R. Liepman, MD, University Hospital, 1405 E. Ann Street, #N2727, Ann Arbor, 48109, 313/764-0170. **Approved for:** 5 hours of Category I Credit.

Date: Oct. 16-20, Family Practice Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: Oct. 18, Diabetes for the Clinician. Location: Kalamazoo Center, Kalamazoo. **Sponsor:** American Diabetes Association, and The Upjohn Company. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Family physicians and internists. **Cost:** $25 physicians, $10 house officers. **Contact:** C. L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 252 East Lovell Room 364, Kalamazoo, 49006, (616) 383-6360. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 18, The School-Age Parent. Location: Mott Children's Health Center. **Sponsor:** Mott Children's Health Center and Hurley Medical Center. **For:** Pediatricians. **Cost:** $12. **Contact:** Richard D. Garlick, Director, CME, Hurley Medical Center, 6th Ave. and Patrick St., Flint 48502. **Approved for:** 5 hours of Category I Credit.

Date: Oct. 21, Regional Infectious Disease Symposium — V.D. Location: Hurley Medical Center, Merliss Brown Auditorium, Sixth Avenue & Begole Street, Flint, 48502. **Sponsor:** Hurley Medical Center. **For:** All specialties. **Cost:** $30. **Contact:** Richard D. Garlick, Director of CME, Hurley Medical Center. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 25, Brief Psychotherapy. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, psychotherapists. **Cost:** $50/$30. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 26, Nutritional Support of the Hospitalized Patient. Location: Troy Hilton. **Sponsor:** Jason Bodzin, MD, Director, Surgical Education, Mt. Carmel. **Cost:** $25. **Contact:** Jason Bodzin, MD, 313/864-5440, Ext. 656. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 27-28, Otorhinolaryngology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otolaryngologists. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 28, Nutritional Support of the Hospitalized Patient. Location: Troy Hilton Hotel. **Sponsor:** Nutritional Support Team, Mt. Carmel Mercy Hospital and Medical Center. **Cost:** $40. **Contact:** Pat Dunkel, Mt. Carmel Mercy Hospital and Medical Center, Detroit. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 31, Continuing Pathology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, U of M Medical School. **For — Specialty:** Pathologists. **Cost:** $25. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 1, Sleep Disorders. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **For:** Primary care physicians. **Cost:** $25. **Contact:** Medical Education Office, 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 2, Second Annual Michigan Family Practice Research Day. Location: MSU University Club, East Lansing. **Sponsor:** Department of Family Practice, MSU College of Human Medicine, and Michigan Academy of Family Physicians. **Contact:** Doug McKeag, MD, Chairman, Research Day Planning Committee, MSU Department of Family Practice, East Lansing, 48824, 517/353-00850. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 4, Current Occupational Health Concerns. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **For:** Primary care physicians. **Cost:** $60. **Contact:** Medical Education Office, 313/876-1464. **Approved for:** 7½ hours of Category I Credit.

Date: Nov. 6-8, Minimal Breast Cancer. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists, surgeons, hematologists. **Cost:** $160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: November 6-10, Counseling Older Adults and their Families; Principles of Milieu Therapy: Working with the Elderly in Treatment Settings. Location: University of Michigan. **Sponsor:** Institute of Gerontology, University of Michigan. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 3.5 hours of Category I Credit.

Michigan physicians may write *Michigan Medicine* for meetings of later dates.

Date: Nov. 7-9, MSMS Annual Scientific Meeting. Location: Detroit Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** MSMS. **For:** All specialties. **Cost:** $4/credit hour for members; $8/credit hour for non-members. **Contact:** Herbert Auer, MSMS headquarters, 517/337-1351. **Approved for:** 20 hours of Category I Credit.

Date: Nov. 10-11, 26th Annual Trauma Day. Location: Harper Hospital, Webber Wing, 3990 John R., Detroit. **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons and WSU Department of Surgery. **Cost:** $60. **Contact:** Joseph L. Posch, MD, 1408 Cales Bldg., Detroit 48226, 313/962-0727. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 13-14, Oncology-Hematology. Location: Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Primary care physicians. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Nov. 15-16, Mammography for Radiologic Technologists. Location: Towsley Center for CME, Ann Arobr. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the U of M Medical School. **For:** Radiologic Technologists. **Cost:** $80. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 14 hours of Category I Credit.

Date: Nov. 16, The High Risk Neonate: A Symposium on Birth Defects. Location: Mercy College, Detroit. **Sponsor:** Metropolitan Detroit March of Dimes Health Professional Advisory Committee, Wayne County Medical Society and Wayne State University College of Nursing/College of Life Long Learning. **Cost:** $30. **Contact:** Joan Leavy, 313/864-6000. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 17-18, Otorhinolaryngology Conference. Location: Towsley Center for CME, Ann Arbor, **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, U of M Medical School. **For:** Otolaryngologists. **Cost:** $120. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 12 hours of Category I Credit.

Date: Nov. 17-18, Medical-Surgical Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians, surgeons. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Nov. 28-30, Diagnosis and Treatment of Arrhythmias. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the U of M Medical School. **For:** Internists. **Cost:** $180. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 21 hours of Category I Credit.

Date: Dec. 5, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

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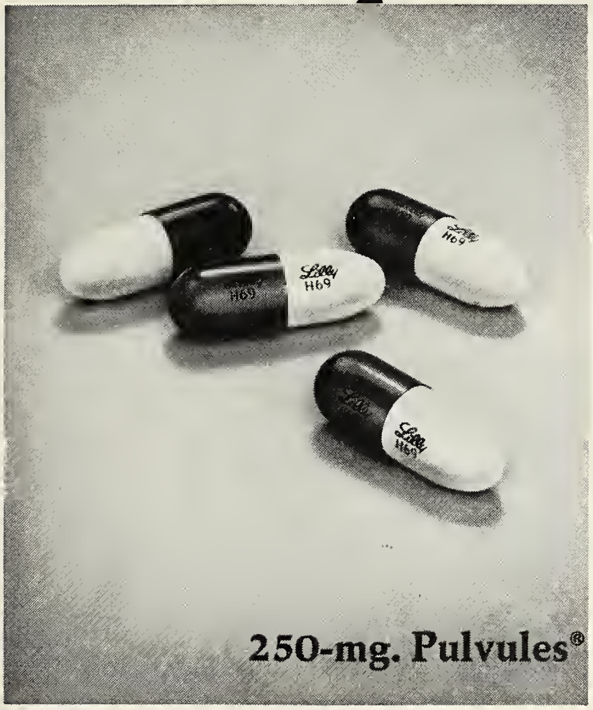
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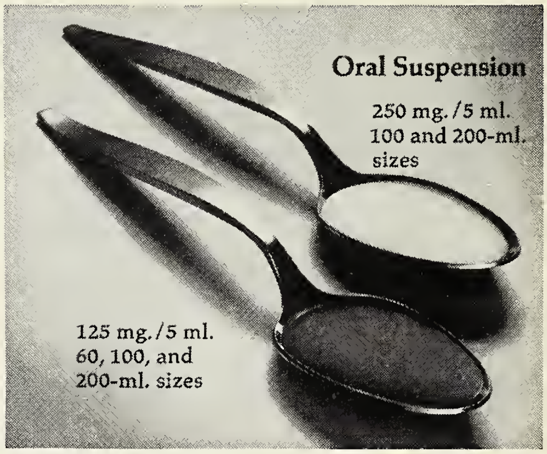
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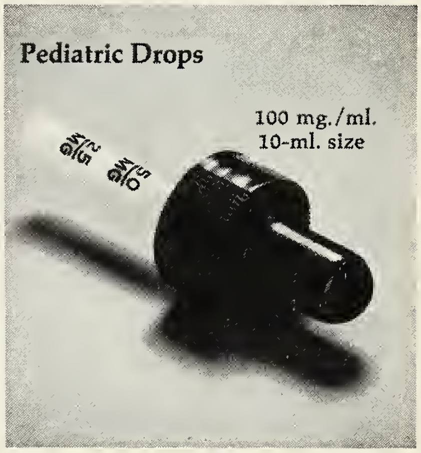
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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

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Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

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Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

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Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

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Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

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When you can't raise fees to cope with rising overhead

By R. Timothy Hogan
Ann Arbor

In the past, as a practitioner's overhead costs increased, staying even financially was a simple matter of adjusting fees upward.

Things are different now. Even though there are justifiable reasons for some increases, there is and will continue to be considerable public and political pressure exerted to stop this upward trend.

Resistance is hardening to further professional fee increases, but at the same time, the practitioner's costs of running a practice continue to climb. Economists foresee at least a four to six percent annual inflation rate for the next 10 years. Partly because of continued inflation, a practitioner's overhead costs have been rising nine to 10 percent a year, and with some expenses, the increases have been significantly greater.

Costs escalating

Look at what's happening with respect to wages and salaries. With the amendment of the Fair Labor Standards Act in 1977, the minimum hourly wage went up from $2.30 to $2.65, effective January 1, 1978. The figure automatically will increase to $2.90 on January 1, 1979, to $3.10 on January 1, 1980, and to $3.35 on January 1, 1981. Even though most practitioners pay their employees more than the $2.65 minimum, compression problems are to be expected. It will be necessary for many professionals to adjust pay scales of skilled employees upward so that the spread between them and the less-skilled workers doesn't shrink so much it leads to office management problems.

Utility bills continue to get larger; fuel bills have been moving up rapidly. Costs for some business overhead items have increased tremendously in the last few years. And, escalation of health care prices generally is reflected in steeper costs for group health and disability insurance as well as other fringes. Taxes, too, increase, as the government's own cost of doing business goes up.

Options open

What can a practitioner do?

— Recoup all income that's due.

— Increase practice productivity; in other words, see more patients to compensate for income lost to larger overhead outlays.

The first option requires renewed attention to systems and procedures in the practice. To ensure payment for services performed, a practitioner must assure that proper mechanisms are in place and functioning properly to bill patients regularly and to meticulously pursue payment. Successful practices consistently show collection ratios ranging from 92 percent to 98 percent. When a practitioner's collections don't fall into this range, there's something wrong somewhere.

Often, it's a lot harder to collect these days. The same inflation that affects a practitioner's income and overhead is hitting patients in their pocketbooks. As a result, more than $1 billion in unpaid bills are abandoned each year by 36 million Americans on the move. More than 500,000 "skip" accounts are turned over each month to professional collectors after efforts by the parties to whom the money is owed fail. Each month 11 million bad checks are written. And every year 200,000 consumers erase their debts by declaring personal bankruptcy. People in the health field, along with retailers and utilities, often are hardest hit with collection losses.

So practitioners must keep a watchful eye on collections, jack up systems not working as well as they once did, and at the same time, encourage patients to pay within a reasonable time period. It's common knowledge the bigger a bill gets and the longer it goes unpaid, the tougher it is to collect in full.

The second option — expanding practice volume — may not have immediate appeal to practitioners who for years have felt they were working too hard already. Yet, as any professional management consultant knows, there are ways of increasing that volume without working longer hours. The answer lies in stepping up the efficiency of the practice itself.

That means placing more emphasis on sound practice management techniques — on improved scheduling that eliminates "down time," on ways to use every minute to best advantage, on delegating more routine activities to well-trained assistants, on sharpening employees' skills and motivating them to perform their roles to the best of their abilities, and sometimes on revamping the office itself for better traffic flow and smoother operation.

Flaws overlooked

When a practice has been running successfully for years, flaws in the operation are easy to overlook. Little things that slow everybody down are simple to ignore. More and more, however, the only maneuverability a practitioner may have in terms of upgrading the practice financially — or even just staying even financially — will be in the area of more efficient management.

Ironically, after nearly two decades in which practitioners were in such great demand that economic problems were largely solved within a year after a new physician began practicing, the profession once again must turn its attention to an old, familiar subject — practice-building.

Mr. Hogan is management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

The advantages to MD and patient of outpatient surgery

By Gerald E. Butler, MD, FACS
Ann Arbor

In 1973 I fractured a leg and was hospitalized. I found out, as a patient, that as soon as the hospital wasn't needed I was far better off at home. This incident started my interest in outpatient surgery.

About three and one-half years ago, the surgery department of Chelsea Community Hospital, opened its outpatient surgical center.

I began, timidly at first, to perform surgery on an ambulatory basis. I'm an otorhinolaryngologist, practicing in Ann Arbor, and much of what I do lends itself to this type of care: tonsillectomies, tympanoplasties, submucous resections of the nasal septum, tympanostomy tubes, minor soft tissue of the neck and many more such cases.

I found myself "selling" the concept to patients at first, but found patients were coming to me rather than to someone else specifically because I was performing these operations on an outpatient basis and others in our area still insisted on the inpatient stay.

Stop and reflect for a moment. What does hospitalization really do for the patient?

Hospital admission is of course necessary when serious or critical needs of the patient must be met by specialized care. However, for a child who is to undergo surgery, say for a tonsillectomy, the trauma is insignificant both emotionally and physically when done as an outpatient. The standard procedure at this outpatient surgi-center is as follows: the patient is brought to the facility the *day* of surgery accompanied by his/her responsible adult companion. Necessary preoperative tests are done to determine their health status. When those results are obtained and evaluated, the patient is examined by the anesthesiologist prior to entering the operating room. The anesthesiologist gives a brief explanation of the type of anesthesia and obtains a signed consent from the adult companion. The patient is then taken to the operating room which is the only time the patient (particularly children) is away from his/her parent or responsible adult. Surgery is then performed and then the patient is transferred to the recovery room. It is fortunate at this surgi-center that the responsible *adult* companion may be with the patient in the recovery room when the patient is awake and stabilized. This is especially conducive to a child's well-being. The patient is evaluated by the surgeon and anesthesiologist before being discharged, specific instructions are given to the responsible adult companion and all questions are answered by the surgeon regarding the operation as well as postoperative care and expectations.

The patient is followed up the next day by a telephone call from the staff, usually by the RN who was involved in the case or by the recovery room RN.

Numerous advantages

The advantages of ambulatory surgery are numerous. First of all, minimum time is spent by the patient in the hospital setting.

What better way can a patient recover than at home where all his needs are met in the environment which is most suitable for rest. He or she can take medications (especially pain medication) *without delay*, may eat or drink when and what is wanted and be most comfortable.

Patients do have to be selected appropriately. Patients who are feeble or very elderly, or who have no one responsible to care for their needs at home are not candidates for outpatient surgery. Sometimes a parent may feel very uncomfortable about taking a child home after surgery and occasionally there may be some complications involved. In these instances the patient is admitted to the connected full service hospital for recovery as long as necessary.

My colleagues were concerned about the complication rate, but in large series of tonsillectomies, for example, the major complication of postoperative hemorrhage was cut in half — an impressive statistic.

My patients are happier, I'm more relaxed and best of all, I am delivering better medical care at a tremendously reduced cost.

Historically, third party carriers started the hospital admission concept because they could not monitor what kind and type of care was delivered in doctors' offices. Therefore, generations of physicians were trained to believe that surgery of any kind could only be performed on an inpatient basis. Since this is not true and, facing spiraling costs of hospitalization, I believe we will have to retrain the attitudes of these doctors and show them in the *appropriate* cases, the outpatient route is not only significantly less costly but is a thoroughly better form of care.

Necessary conditions

There are several major conditions necessary for outpatient surgery.

A facility oriented or designed for this specialty must be available, there must be a staff equally oriented in the concept and, also of importance, it should be attached to a full service hospital.

As I intimated in the beginning, outpatient surgery is here to stay! It is the preferrable route for a large percentage of patients in the future and whether some of the physicians accept the concept or not, it will be demanded by the third party carriers in the future.

With the close, personal relationship you establish with the patient as well as his/her responsible party it certainly will not increase your malpractice risk but certainly significantly reduce it!

Try it — you and your patient will like it!

Doctor Butler is an otolaryngologist.

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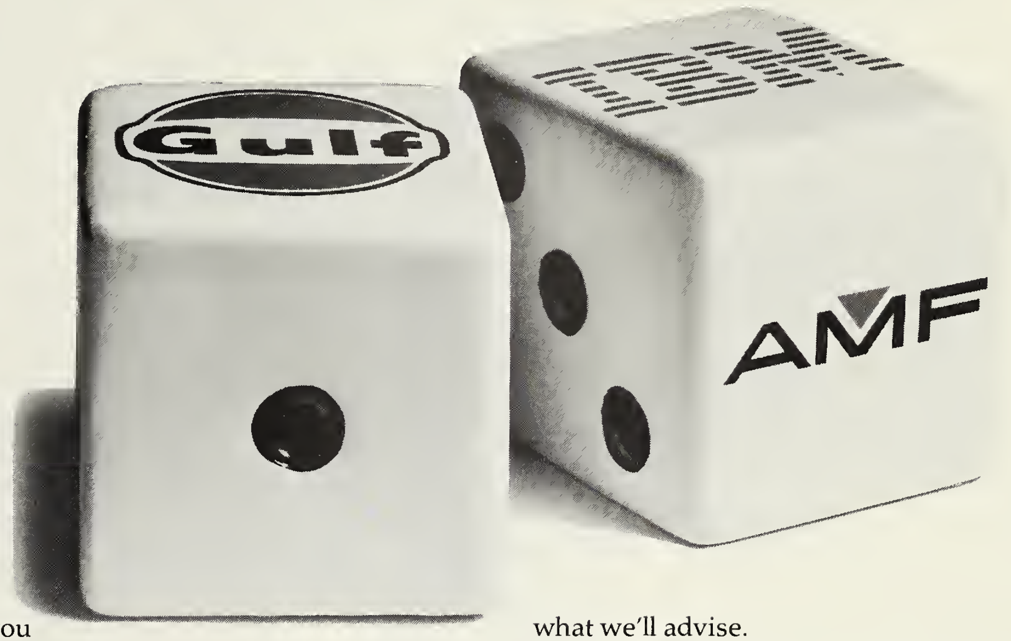

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Learn more about public policies affecting medicine at MSMS workshop

What does PHSRP mean to doctors?

What changes in the federal planning act will affect doctors?

Sould Certificate of Need reach doctors' private offices?

Why does change occur?

These questions and many more will be answered at an all-day MSMS public affairs workshop planned Sept. 20 in Ann Arbor. The workshop will be open to all MSMS members.

"Anticipating Change" is the theme of the workshop which will explore the statutory and regulatory changes taking place in the delivery of health and medical care.

The workshop is being presented by the MSMS Committee on State Legislation and Regulation at the Marriott Inn, Ann Arbor, from 10 a.m. to 4 p.m. Sept. 20.

The morning session will consist of AMA and MSMS leaders reviewing changes in 1978 in health care delivery, both state and nationally. The afternoon session will provide physicians an opportunity to hear from health planners, third party payors, and patients on their plans and proposals for the future of health care.

A luncheon address offering thoughts on the philosophies of change will be delivered by speaker-emeritus of the Michigan House of Representatives, Rep. William Ryan.

Conference chairman, Oliver D. Grin, MD, Grand Rapids, encourages all physicians to attend to promote the continued ability of the medical profession to influence and shape the future of health care delivery.

Reservations currently are being accepted through MSMS. For information, please contact Bruce Ambrose or Gary Anderson. Registration is $15, including lunch.

Please detach and mail this form to following address.

Division of Government Relations
Michigan State Medical Society
120 West Saginaw St.
East Lansing, MI 48823

I will attend the Public Affairs Conference at the Marriott Inn, Ann Arbor, September 20. I will bring ________ physicians with me whom I think should benefit from the program. Enclosed is my check for $ ________ ($15 per person).

/s/ ______________________________ MD

With me will be ______________________________ MD

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Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

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Michigan's only AMA trustee believes AMA keeps profession viable

By C.R. Shelton
Special to **Michigan Medicine**

John J. Coury, Jr., MD of Port Huron is Michigan's only American Medical Association Trustee.

Now in the second year of his three-year term, Doctor Coury estimates he spends 90 days per year traveling on AMA business. He states the only way he is able to maintain that schedule is because he has understanding associates in his office, plus an understanding and patient wife.

There are 12 AMA trustees who are elected for three years and are eligible to be re-elected for an additional three year period. Trustees are chosen by the more than 250 members of the House of Delegates. Michigan has eight delegates plus eight alternates.

Doctor Coury, who is a surgeon, says the basic function of Trustees is to carry out the everyday duties of the AMA's House of Delegates. Trustees meet every four to six weeks, usually in Chicago.

Among their many activities are: representing the association at various state medical society functions, testifying on legislation — if needed, meeting with other medical or civic organizations to present the AMA's views and/or answer questions, and, at times, to meet with the press.

As a Trustee, Doctor Coury is a representative of the AMA Board of Trustees, the Council of Constitution and By-laws, Council on Planning and Development, Finance Committee, Speaker's Bureau, and the Review Committee.

AMA dedicated, concerned

The AMA is a viable, dedicated and concerned organization, declares Doctor Coury. It operates on a budget of about $50,000,000 per year, and approximately 85 percent of the budget goes into efforts to improve patient care, continuing education for physicians, and work aimed at cost effectiveness in health care. Contrary to the opinion of many, Doctor Coury adds, only about one percent of the budget is spent on lobbying.

He estimates at this time approximately 50 percent of practicing physicians in this country hold an AMA membership. "This is far too few, and one of the things we need is for more physicians to become members of the Association.

"No physician, whether a member or not, could ever begin to repay the association for what it has done for our profession," he states.

"For instance, the AMA was one of the strongest forces in getting the Kegoh Plan enacted. That one fact alone is worth supporting the association when one considers that through this plan physicians can set aside retirement funds to allow them to retire gracefully and with dignity. For many of us that just wouldn't be possible the way costs are today and probably will be in the future.

"Additionally, the association has the largest continuing education curriculum in the world, insurance programs that can be invaluable, and it offers physicians an opportunity to be a part of an organization that is trying to help maintain the highest quality of health care, while keeping the medical profession independent.

National medical voice

"There are many other valid reasons why all practicing physicians should be members, but one I think all doctors should consider is that the AMA is the only medical voice heard nationally. Congress listens to us. When necessary, we are able to take certain matters to court, and to try to contain the evergrowing regulatory actions of various groups. Quite frankly, if we didn't have a national voice, the medical profession would not be viable much longer.

Doctor Coury

"The association needs every physician to help make its voice stronger," Doctor Coury stresses, "and to assist in keeping the medical profession independent. If our profession goes down the socialized medicine drain — as has happened in other countries — then sooner or later everything else in this country will be socialized."

Doctor Coury believes one reason there are not more AMA members is that some of the younger doctors who were a part of the discontented

DOCTOR COURY/*continued*

1960's college students — and who developed a negative attitude toward most of the so-called establishment — are now entering practice and still do not want to be associated with the national organization.

"Also, I realize the $250 a year dues are high, and that physicians belong to other groups which are equally expensive. However, if there were more AMA members, the cost of being a member could probably be lowered."

Bright future ahead

Notwithstanding all of this, Doctor Coury feels the future looks bright for the association.

"Recently there has been a great increase in the number of medical students, interns and residents who have joined the AMA. Two years ago there were less than 10,000 in that category; today there are approximately 28,000."

This increase came about, in part, because the AMA has given students, residents, and interns a voting voice in the association and has encouraged their active participation on all major Councils.

"The association went to bat for students on the Health Manpower Bill, which, if passed, would have meant all medical graduates would have been indentured servants of the government. Under that bill, they would have gone into some type of government service for a certain length of time in an area designated by the government.

"The association also was instrumental in getting the law passed that assures no military conscription for physicians unless there is a war, or dire national emergency.

"These young people have added greatly to the association. They are responsible and are an excellent addition to the House of Delegates. I don't always agree with them, but their criticisms are constructive and sincere, and they have strengthened the entire organization.

"In all probability, they will continue their AMA membership when they are practicing, so I believe the association is headed for some very productive years."

Talk cost effectiveness

Doctor Coury emphasizes the American Medical Association is dedicated to improving medical care in this country, to seeing every dollar spent on health care is cost effective — by making sure every medical test made on a patient is needed, patients are placed in hospitals only when absolutely necessary, and are released as soon as possible.

"Most people talk cost containment, but we talk cost effectiveness because medical care must be effective and delivered at the lowest cost possible."

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Calendar for AMA, MSMS auxiliary and medical assistants

MSMSA

(See also listing of Category I programs on page 494)

Sept. 23-24 — Medical Assistants Fall Training Seminar, Roseville, contact: Helen Schulte, MSMS headquarters.

Sept. 26-27 — Auxiliary District Meeting, Mt. Pleasant, contact: Helen Schulte, MSMS headquarters.

Oct 18-19 — Auxiliary District Meeting, Marshall, contact: Helen Schulte, MSMS headquarters.

Nov. 1 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 7-9 — MSMS Annual Scientific Meeting, Detroit Plaza Hotel, contact: Herb Auer, MSMS headquarters.

Dec. 2-6 — AMA House of Delegates Interim Meeting, Chicago.

Dec. 7 — AMA Winter Scientific Meeting, Las Vegas.

Dec. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Feb. 3-4 — Medical Assistants Midwinter Seminar, Jackson, contact: Helen Schulte, MSMS headquarters.

Feb. 28-March 1 — MSMS Maternal and Perinatal Health Conference, Hyatt Regency Hotel, Dearborn, contact: Herbert Auer, MSMS headquarters.

March 4 — Medical Assistants Board Meeting, MSMS headquarters, contact: Helen Schulte, MSMS headquarters.

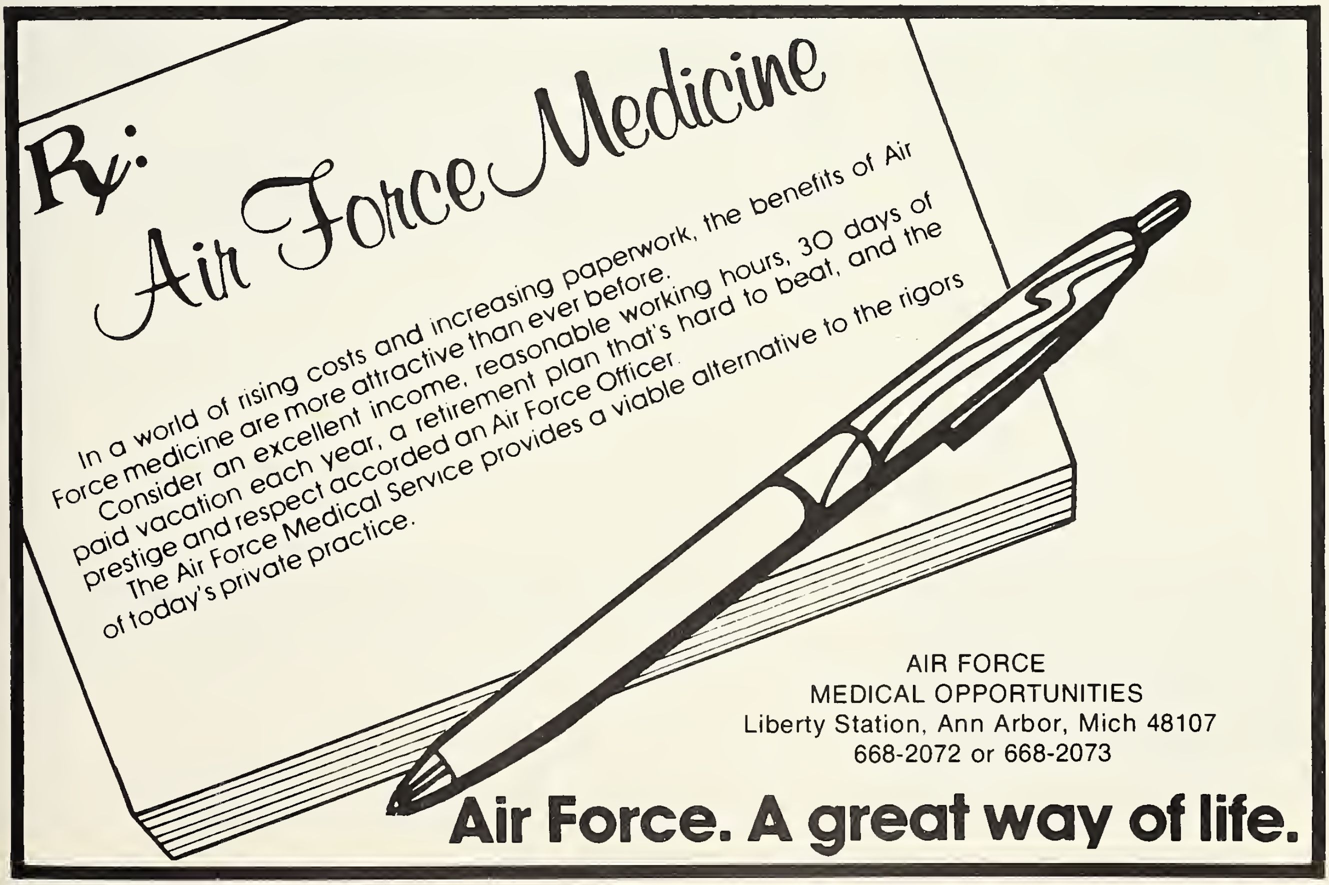
April 26-29 — Medical Assistants State Convention, Lansing, contact: Helen Schulte, MSMS headquarters.

WCMS dinner-dance Nov. 18 this year; at Radisson-Cadillac

Nov. 18 is the date of the annual Wayne County Medical Society Auxiliary dinner dance. The location will be the newly-renovated Radisson-Cadillac Hotel in downtown Detroit.

The evening, which will include dinner, dance, entertainment, a silent auction and other special activities, will benefit the WCMS Detroit Science Center project.

Each WCMS Council member will have tickets to sell. Regular tickets will sell for $50 per person, with $75 patron's tickets and $100 benefactors' tickets also available.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The Grand Rapids Clinical Oncology Program a combined effort of the acute care hospitals in Grand Rapids, Michigan is pleased to announce a one day

Symposium On Recent Advances in Cancer Care

Tuesday, September 26, 1978
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— Featured speakers will include: Arvin Glicksman, M.D., Professor and Chief of the Section on Radiation Medicine, Brown University; and Margaret Sullivan, M.D., Chief of the Division of Hematology-Oncology, M. D. Anderson Hospital.

— 11 hours of Category I CME credit have been approved for this symposium.

— For information and pre-registration, physicians interested in optimal cancer care should contact Nancy Holleman, sec., Continuing Medical Education. (616) 774-1835.

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MSMS protects your legal status as a doctor.

MSMS protects the public against exploitations by quacks and frauds, and keeps medical competition on a professional plane.

MSMS controls the depredations of that small minority of doctors whose interest in the profession is only an economic one.

MSMS promotes and guides the prepayment plans and other economic devices designed to help patients pay for your services at the least burden and sacrifice to themselves.

MSMS helps your profession to meet its collective responsibilities to the public and avoids the necessity of the public resorting to political devices to solve these problems.

MSMS provides for you those personal benefits, services, and representations impossible to secure and maintain as an individual.

MSMS helps you to survive and have your voice heard as a responsible professional in an increasingly interdependent and socialized society.

Donald K. Crandall, MD (foreground), MSMS Chairman of the Physician Liaison Committee, listens as Blues' spokesman Frank Blackford (to Doctor Crandall's right) presents his point of view. Other participants down that side of the table are (from left to right) Joseph Velkey (BCBSM), William Madigan (MSMS), Louis Hayes, MD (BCBSM), Robert Asmussen (BCBSM), Daniel Kehoe (BCBSM) and Ellsworth Reynolds (BCBSM).

Medicine is ably represented on the Physician Liaison Committee by (left to right) Frank B. Walker, II, MD; John B. Bryan, MD; Edward Loniewski, DO; MAOPS Director George Abdilla, and MSMS staffers John Richards and John Anthony. Opposite Doctor Walker is BCBSM representative Frank Blackford.

Scenes of MSMS/Blues Liaison Committee meeting

BCBSM team member Robert Asmussen explains a BCBSM report.

Former state department director talks about mental health care

By Donald C. Smith, MD
Ann Arbor

Physicians who graduated prior to the 1960's are not unfamiliar with the public mental health system. Visits to one of the "state hospitals" and to a "state home and training school" were part of one's undergraduate training in psychiatry and pediatrics. The common reaction to these visits was one of marvel and despair.

Now it is possible for medical students to graduate without these experiences. Their knowledge of mental health problems — "out there" — may come from the six o'clock news ("Investigation reveals mental health patients have sexual experiences — See tonight's eleven o'clock *News Final*") or from a newspaper headline ("State Senator Demands Mental Health be Probed"). The young professional's most telling description of the problems associated with the psychopathic personality may well have come from Jack Nicholson's skillful portrayal in "One Flew Over the Cuckoo's Nest" — mass entertainment, successfully disguised as documentary.

Michigan's department of mental illness and developmental disabilities,* more commonly known as Department of Mental Health, is a public agency whose actions, directly or indirectly, affect every family in the state. It is the state's largest single provider of health care services. In 1976-77, a total of some 203,000 persons received services from one or more components of the public mental health system. Forty-six thousand of these individuals received care in one of our 23 regional psychiatric hospitals and centers for developmental disabilities; 156,000 received care and treatment from one of the state's 55 community mental health centers. For these services, Michigan citizens provided $291,000,000 in state tax funds. The federal government added another $44,000,000. (Next year it will be $412,000,000 in state monies).

Some background

Who are the individuals and families who come for care? What are their problems? What kinds of care do they receive? What are the results?

Traditionally, state mental health institutions care for the very sick, the poor and the disenfranchised, and are almost the sole resource for admission of involuntary patients who need intensive treatment. In fact, patients coming to the Michigan Department of Mental Health comprise a heterogeneous group. They come from all regions of the state. They represent every age group. They receive a wide spectrum of services, uneven in quality. A significantly high percentage of the patients admitted to a regional psychiatric hospital are young and middle-aged adults. The most common diagnoses are "schizophrenia," the "affective disorder," and "chronic brain syndrome."

One can only speculate in regard to the nature and cause of the disorders presented by those who come to a community health center for care. In 1976-77, less than 20 percent of CMH records included a psychiatric diagnosis.

Nearly 80 percent of the persons admitted for the first time to a regional center for developmental disabilities are under 21 years of age; some 23 percent are under six years of age. The primary diagnosis is "mental retardation," but a significant percentage have multiple disabilities, especially cerebral palsy, convulsive disorders, vision and hearing problems, and metabolic defects.

The impact of mental health services is difficult to determine. Outcome measures are notoriously uncertain. We do know that more than 50 percent of all psychiatric inpatients are discharged in less than 15 days; 80 percent in less than three months; and 90 percent in less than six months. Fifteen percent of the discharged patients are identified as having chronic problems and requiring community placement and aftercare services. Eighteen percent of the persons admitted to a regional DD center (including some who come for "respite" care) are discharged in less than one month. Forty percent are discharged in less than one year, but almost as many (39 percent) stay for more than four years. In contrast to the psychiatric hospital experience, only 15 percent of the patients discharged from a regional DD center return directly to their homes.

Medical model

Current views on the nature of mental illness and its possible causes are remarkably varied and changing in character. The "medical model" of mental illness has been under attack for some time, notably by those who see mental disorders as essentially a response to a difficult or hostile environment. It has become a straw man used for this purpose by persons who fail to understand and choose to

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Doctor Smith was director of the Michigan Department of Mental Health from 1974 to 1978 and now is professor of maternal and child health and pediatrics at the University of Michigan.

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* Mental retardation, epilepsy, cerebral palsy, autism

minimize biological factors in either the causation or treatment of mental illness and mental retardation.

This attitude is unfortunate and ironic. New knowledge in the biochemistry and pharmacology of mental illness now make it possible not merely to attach labels to psychiatric disorders, but to understand their pathogenesis and to rationally develop appropriate plans for treatment and care; new knowledge from the fields of genetics, obstetrics, pediatrics, and neurology make it possible to much more accurately diagnose and even predict the occurrence of a wide range of developmental disabilities.

The medical model may well have limitations (although these have not been well documented). But it does have the capacity to respond to the needs of that large group of mental health patients who have associated health care problems, for example, a neurological disorder, hypertension, cardio-vascular disease, or diabetes. In light of this knowledge, it is not easy to explain why so few community mental health centers in Michigan (or elsewhere in the nation) provide screening mechanisms directed toward identification of these kinds of problems. There appears to be an underlying assumption that they either do not exist or that their presence is not significant to the "client's" rehabilitation program.

Another popular straw man is "the institution." Because some institutional care is demonstrably inadequate, all institutional care (so the argument goes) is bad — and must be abandoned. This deceptively simple proposition overlooks the harsh reality that at certain critical stages in their illness many mental health patients require specialized, intensive care that can only be provided in a hospital setting.

The community care ideology developed from the growing realization that the mental hospital in its traditional form did much to isolate the patient from his community and to undermine his motivation and ability to return. An early and continuing hypothesis is that organized mental health services developed at the community level serve to markedly lower the need for hospitalization. This assumption, which became sacrosanct, is now open to question. There is a good deal of evidence to suggest that most persons who come to a CMH center for care have problems which are quite different in nature and severity from those admitted to a public psychiatric hospital or center for development disabilities.

Community and hospitals

Rapprochement between those advocating community programs and those wishing to improve hospital programs is essential. New emphasis must be given to skilled outpatient care and short periods of hospitalization when necessary. On the basis of recent experience and current knowledge, alternatives which fall somewhere between community and hospital outpatient care and the total separation characterized by traditional mental hospital inpatient care must be developed.

The prevailing gap between medicine and mental health must be diminished. All available evidence suggests that in the next several decades problems associated with the incidence of mental disability will increase. The practicing physician will continue to have a crucial role in both the early recognition and the management of mental illness and developmental disabilities. He will need the support of the public mental health system, and his active involvement in that system will help to keep it alive and functioning.

Recognition needed

But are not public health systems inherently inferior and is not working in them professionally unrewarding? Don't they attract incompetent persons? Is it not true that major public policy decisions tend to ignore substantive issues and are predominantly determined by short-range political expediency and pressures of social reform? As mental health systems grow larger and their proponents more vociferous and as health and welfare themselves become central public issues, does not political interference in professional care and treatment become more and more obvious? Is not the press, with its relative unaccountability to any specific individual or group in the public arena, a constant source of destructive harassment?

Doctor Smith

The answer to these rhetorical, yet relevant, questions is "sometimes." There are inherent rigidities which make it difficult — sometimes impossible — to deal with powerful forces for change sweeping through our society, profoundly affecting the way we respond to the needs of the mentally disabled.

We are in the midst of historic changes in our concept of the extent to which every person has a right to health care, including mental health care. We are trying to stretch our health care system toward those ends. This cannot be accomplished by the public sector alone. The private practitioner has a role not always recognized either by those in private practice or by those in public health systems. This recognition is a prerequisite; only then can we devise ways and means of bridging the gap between the public and private sectors capitalizing the strengths of each. Many of us who are in responsible positions believe deeply in this cause on which we are glad to expend both our energies and our careers.

Auxilians welcome opportunities to work closely with medical society

By Anita Yannitelli
Battle Creek

Great strides are being taken in the expansion of communications between the Michigan State Medical Society and its Auxiliary, creating high expectations for a productive year ahead.

Although MSMS and MSMS-A have worked together in the past, it has been more or less in a parallel fashion. Any units can accomplish more, however, when there is an active dialogue.

As Mrs. Edward R. Weddon, State Auxiliary president has pointed out, "The purpose of our auxiliary is to help the medical society obtain its objectives and this can best be done by working together."

Working together calls for talking together and this is why we were so pleased when Louis E. Heideman, MD, MSMS president, agreed to serve as an auxiliary advisor this year.

"I urge all auxilians to continue their efforts in AMA-ERF, the immunization-awareness program and legislative matters; and to continue to assist in educating the public in matters relating to the medical profession," he stated. His support has already been felt in several areas of auxiliary aspirations.

Further bridging the gap between the society and auxiliary, Louis R. Zako, MD, chairman of the MSMS Council, has invited our president to be his guest at a forthcoming Council meeting. Although 26 states have an auxiliary representative attending their council meetings, this is a "first" for Michigan and we are very pleased with the possibility this may become a frequent event. Being able to learn, first-hand, the concerns and plans of the society from our president should give our members added incentive to help in any way possible.

In keeping with our working-together concept, Warren Tryloff, MSMS director, has offered to keep Auxiliary representatives to the AMA-A convention informed about plans of the MSMS representatives to the AMA convention. Staff members also are planning to coordinate activities with the auxiliary and the medical society during the 1979 state convention in Kalamazoo.

Herbert Auer, MSMS deputy director, is including auxiliary participation in plans for the 1978 MSMS Annual Scientific Meeting, Nov. 7-9, at the Detroit Plaza.

Another highlight of this year is *Michigan Medicine* carrying articles submitted by the auxilium editor and others she appoints. Judy Marr, managing editor, is "making room" for these auxiliary reports and providing expert assistance.

MSMS has, through the years, given invaluable aid to the auxiliary by funding our newsletter, "Auxilium," and office services. Without Helen Schulte and her staff, we might well be floundering in paperwork.

For all these things we are most appreciative. Particularily, however, we welcome the opportunity to work more closely with MSMS and will do our best to fill new responsibilities.

***Mrs. Yannitelli is editor of the Auxiliary's newsletter, the* Auxilium.**

Mrs. Yannitelli

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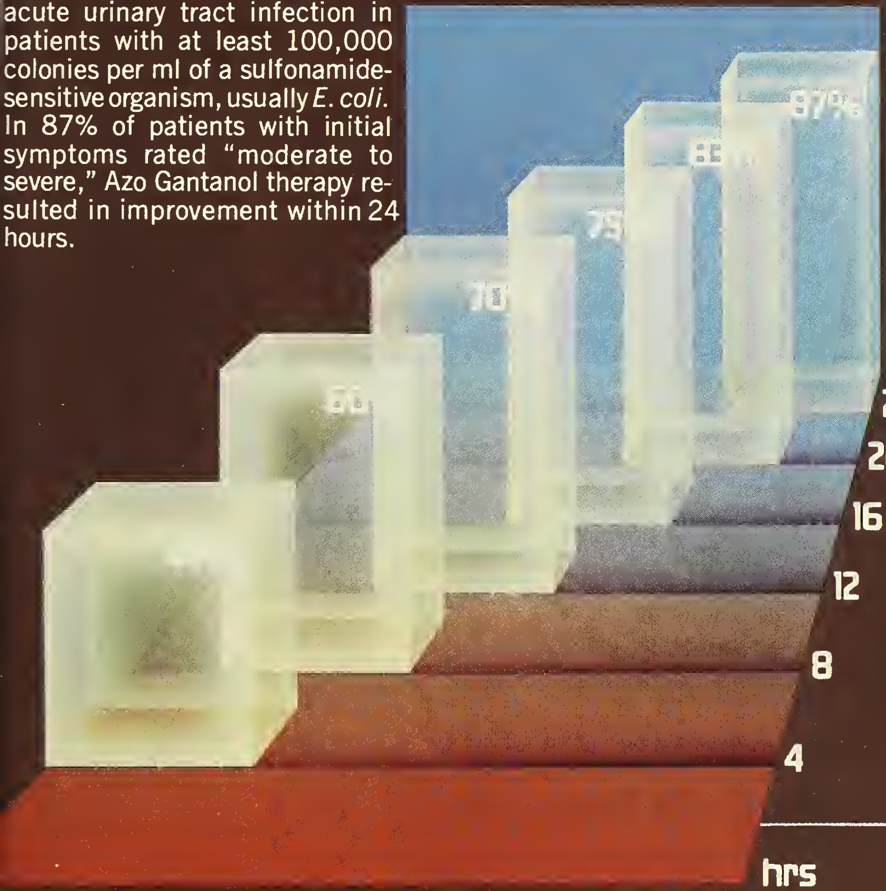

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Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

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Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

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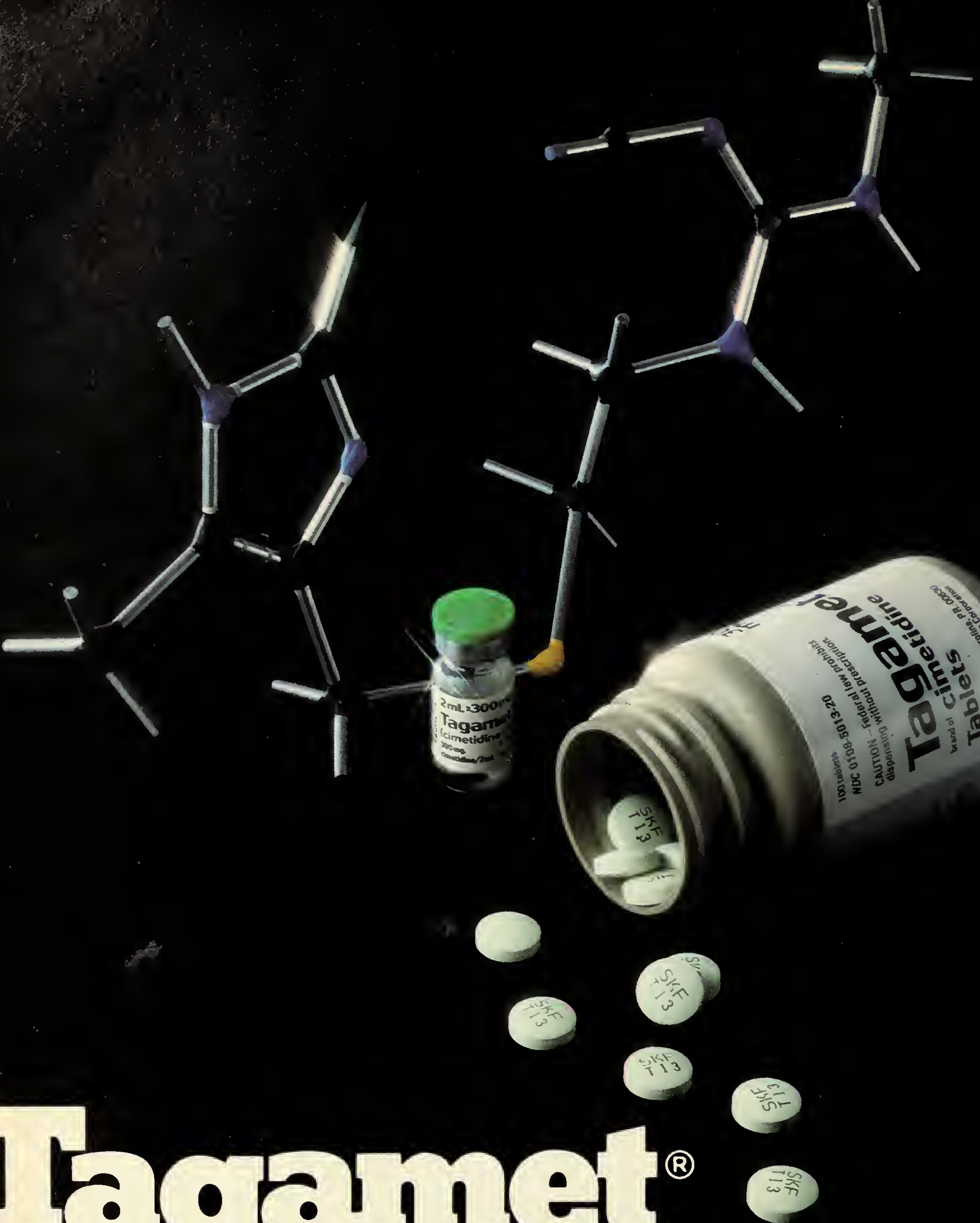
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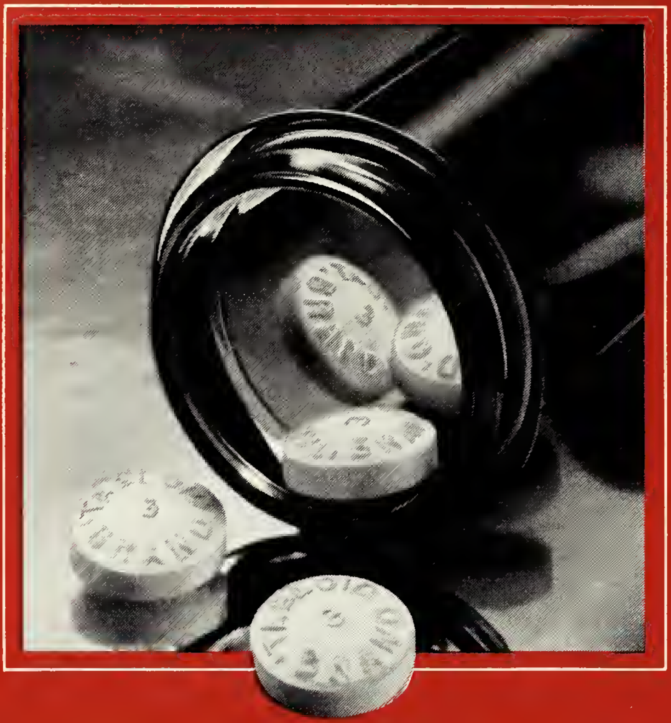

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By Katie Brewbaker, MSMS staff

Joseph H. Beer, MD, is proof there are no barriers to fulfilling that "impossible dream." This summer the retired St. Clair physician left the West Coast in his 36-foot sailboat, the Mistral, and 20 days later dropped anchor at Diamond Head, Hawaii. Now he's dreaming about another trip — this time on a bicycle — across the United States. So, keep your eyes open for a smiling gentleman peddling along Route 66 next summer.

Chairman of the Michigan Department of Public Health's new permanent Advisory Technical Committee on Immunization Practices is **Edward L. Quinn, MD,** head of Henry Ford Hospital's Division of Infectious Diseases.

The Jerome W. Conn Award has been awarded to a U-M liver disease specialist, **Jorge J. Gumucio, MD.** The award is presented annually by the U-M Department of Internal Medicine to a faculty member for distinguished clinical research. Doctor Gumucio was recognized for his research into the possibility that groups of cells in the liver have different functions which change if the cells are damaged or disabled.

William N. Kelley, MD, of Ann Arbor, is new president-elect of the American Federation for Clinical Research. Doctor Kelley is chairman of the U-M Department of Internal Medicine.

Nicholas Lentini, MD, recently received a citation from the board of trustees of the Community Memorial Hospital at Cheboygan for his 31 years as an officer of the medical staff and as its long time chairman.

The *Grand Rapids Press* recently carried a warm feature about **C. Allen Payne, MD,** MSMS past president, former chairman of the Medical Practice Board, and past president of the Michigan Society of Pathologists. Doctor Payne was saluted for his long service for efforts in the fields of cancer education and the blood bank program. After 36 years as director of laboratories and pathologist in chief for Blodgett Memorial Medical Center, he retired in 1974. He is program director of the Grand Valley Blood Program and works daily at his office.

The American Cancer Society's Professorship of Clinical Oncology has been awarded to **Leif S. Suhrland, MD,** MSU Professor of Medicine. The professorship covers a five year period. Doctor Suhrland is recognized for his work in hematology and oncology and for his research in developing appropriate treatment for the control of malignant cells, toxicity of chemotherapeutic agents and clinical problems in cancer treatment.

Recent issues of *JAMA* featured articles by Michigan physicians. Doctors **Luis C. Maas, Eugene A. Gelzayd, Varin Uppaputhangkula,** and **Boris Silberberg,** of Providence Hospital, Southfield, are co-authors of "Endoscopic Removal of an Ulcerated Appendiceal Stump" that appeared July 21. The following week "Simultaneous Serum and CSF Antibodies in Herpes Simplex Virus Enceophalitis" was carried in *JAMA*, written by Doctors **Donald P. Levine, Carl B. Lauter,** and **A. Martin Lerner** of Hutzel Hospital, Detroit.

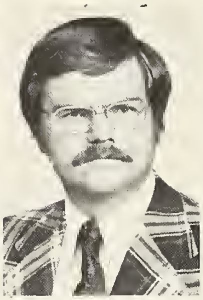
"Quality of Life for Long-Term Survivors of End-Stage Renal Disease" is the subject of a *JAMA* article by Ann Arbor physicians **Elva O. Poznanski, MD,** and **Robert C. Kelsh, MD,** in cooperation with Emily Miller, MSW, also of Ann Arbor and **Carlos Salguero, MD,** of Yale Medical School.

W. Donald Weston, MD, Dean of the MSU College of Human Medicine, has been selected chairman of the Michigan Medical School Council of Deans. His term will begin in September.

Graduates of the Kresge Eye Institute have honored **H. Saul Sugar, MD,** Detroit, by awarding a special educational travel stipend in his name to the second year resident who "displayed highest ability academically, surgically, and clinically." Doctor Sugar was cited for his many years of service to the Detroit General Hospital training program.

As **John Vrbanac, MD,** leaves Hart, a community where he has practiced for 30 years, for the new Regional Health Care Center in White Cloud, he will take with him memories of grateful friends and patients who showed their appreciation at a special dinner in his honor.

Two general surgery residents from the University of Michigan are recipients of the Frederick A. Coller Awards. Doctor **Maria Allo's** research paper on "Prevention of Clindamycin-Induced Clostridium Sordell II Antitoxin" was awarded first place. Doctor **Jikron Sottiurai's** presentation on "Comparative Evaluation of Transplanted Vein Grafts Preserved in Different Media" received a third place award.


Doctor Kelley

Doctor Payne

Doctor Quinn

Doctor Vrbanac

Disciplinary actions of the Medical Practice Board taken in April, May and June, 1978

The following actions of the Michigan Medical Practice Board are taken from an official memorandum to MSMS and are not editorialized.

April — John W. Moore, MD, Detroit. Doctor Moore's license was suspended for 90 days and the board sought surrender of his DEA and CSR for one year. Suspension on appeal.

— Carleton Brown, MD, Southfield, had his license suspended for one year and permanently surrendered his DEA and CSR. Suspension on appeal.

— Alvin R. Lewis, MD, Grand Rapids. Stipulated that Doctor Lewis had been adjudicated mentally incompetent. License revoked.

— Theodore L. Hughes, MD, Detroit. Doctor Hughes was placed on probation for one year and issued a limited license, minus a CSR or DEA registration. Effective date of final order, May 3, 1978.

— Richard W. Sundling, MD, Chelsea. Board approved issuing of a limited license. Effective April 6, 1978.

May — Primitivo P. Rivera, MD, East Detroit. License revoked. Effective May 11, 1978.

— Gregory T. Sobczak, MD, Muskegon. Board issued a letter of reprimand.

— Dean Paul Rieger, MD, Ann Arbor. Board lifted restrictions of limited license and full licensure granted.

June — Edward W. Walters, MD, Detroit. Petition for reinstatement for unlimited license granted.

— Robert H. Hydrick, MD, Grand Rapids. Suspended license. Term expired. May 9, 1978, a limited license issued for one year minus a CSR or DEA registration. Effective date of limited license June 1, 1978.

Detroit gains recognition as comprehensive cancer center

Detroit recently was recognized as a Comprehensive Cancer Center by the National Cancer Institute, Washington, DC.

HEW Secretary Joseph Califano announced the Comprehensive Cancer Center of Metropolitan Detroit is the 20th in a group of major institutions recognized as 'comprehensive' under the authority of the National Cancer Act of 1971.

The Michigan Cancer Foundation and Wayne State University are the organizing members of the Center.

Said Califano, "Such a designation means the people of Michigan will have access to the finest techniques for the diagnosis, treatment and prevention of cancer that medical science can offer."

Arthur C. Upton, MD, director of the National Cancer Program and of the National Cancer Institute, said, "The achievements over the past six years in planning and developing a truly comprehensive cancer center in Michigan have been viewed by the National Cancer Institute with great satisfaction. We recognize that Michael J. Brennan, MD, director of the Comprehensive Cancer Center of Metropolitan Detroit, is uniquely responsible for 25 years of extraordinary progress in cancer research, patient care, training and control activities now so visible in the Detroit area."

Brennan said two significant facilities are planned as part of the Comprehensive Cancer Center. "Wayne State University has already announced its plans for a $10 million central radiation therapy unit to be built in the Detroit Medical Center, to contain a neutron generator, one of only six in the United States used for patient care and research.

"Also, the Michigan Cancer Foundation will soon make public the details of its plan for expanding its chemical carcinogenesis research facilities with a $3 million installation. These are significant additions to both the treatment services and research activity of the Comprehensive Cancer Center."

Along with two organizing members, Wayne State University and the Michigan Cancer Foundation, there are 23 affiliated members of the Comprehensive Cancer Center. These include 16 area hospitals and the Detroit Medical Center Corporation; the Health Departments of Wayne, Oakland and Macomb Counties and the City of Detroit; the Wayne, Oakland and Macomb County Units of the American Cancer Society and the State of Michigan Vocational Rehabilitation Service.

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Oakland University establishes model for employee preventive health program

By Alfred W. Stransky, PhD
Joseph Arends, MD
Troy

At a time when employee fitness and preventive health programs are mushrooming around the country, the State of Michigan, with its very large industrial base, has failed to keep pace. Corporations such as Kimberly-Clark, Sentry Insurance, Xerox, Northern Natural Gas Company of Omaha, Phillips Petroleum, Rockwell International, Goodyear Tire, Metropolitan Life, Mobil Oil, Exxon and Anheuser Bush have developed programs in prevention which have been designed to decrease the estimated $20 billion lost by American business due to the premature death of their employees and an additional $3 billion loss due to various types of illness. It has been estimated myocardial infarction alone costs American industry $132 billion in lost work days per year.

Oakland University in Rochester, has recently developed a preventive health program for administrative professionals. The scope of the preventive health program is one of the most extensive ever developed within a university setting. Ninety-five percent of all employees eligible to participate have elected to be evaluated. Faculty at the university also have expressed an interest in developing a similar program.

Unlike other programs of prevention and health screening, Oakland University's preventive health program is practitioner-led. It is our belief this program will be more successful in motivating individuals to change their life style if the individuals leading the program are not obese, sedentary and smokers. Patients are not asked to do anything the program directors are not doing.

Oakland University's administrative professional employees elected to move towards a program of prevention as a fringe benefit rather than having annual physicals.

1. Conventional medicine cannot adequately prevent the major cause of death in this country — cardiovascular disease.

2. There was need to improve the life styles of those involved.

3. The traditional physical examination places too much emphasis on direct medical care and does not provide for adequate education and motivation of the patient.

This program is strictly a volunteer program. After it has been determined that an employee is interested in participating in the program, an extensive medical history is taken, including body compensation determination.

After the physical evaluation has been performed, the results are evaluated by an exercise physiologist and a physician who specializes in preventive medicine. The employee is invited to review his health profile with a staff member. Secondly, the consultation period involves a significant amount of patient education. The purpose of this program is to provide information regarding each assessment so a clear understanding is obtained with regard to the effects of life style on each measurement. Finally, prescriptions are provided for continuous exercise programs, dietary modification and appropriate life-style modifications which may help to prevent premature death due to cardiovascular disease.

Long range goals

The major objective of this program is to document the effectiveness of a preventive health program in changing the health status of the employee. An attempt will be made to work with the insurance carrier for the university to determine the effectiveness of the preventive health program in reducing medical costs.

This program also will involve long-term education. A variety of seminars dealing with health topics as well as a periodic newsletter dealing with information concerning prevention are planned.

One of the most important aspects of the program will be the follow-up. Individuals participating in the program will be periodically contacted and assistance will be available in the area of preventive questions and concepts.

The evaluation and consultation provided the patient in this program does not replace the work of patients' personal physicians, but only supplements it. Risk factors associated with the major cause of death in this country will be evaluated.

Doctor Stransky is director of the Oakland University Exercise Physiology Laboratory. Doctor Arends is on the faculty of the Wayne State University Department of Family Medicine. Both are course directors for the 1978 MSMS Annual Scientific Meeting Nov. 7-8-9 at the Detroit Plaza.

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Laura Settler, R.N. — Cleveland Clinic Foundation
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Angela Wallenbrock, M.D.
Richard D. Watkins, M.D.
Robert M. Zimmerman, M.D.

Classified

Positions open

MARQUETTE, MICHIGAN — Expanding referral center has positions available both immediately and in the future for an allergist and a part-time director of medical education. Also needed are additional physicians in the following specialties: obstetrics, gynecology, hematology, oncology, pulmonary disease, primary and consultative internal medicine, and dermatology. Fully equipped hospital with: advanced lab facilities, CT Scanner, active cardiovascular surgery, active participation in the training of MSU medical students, and a family practice residency beginning in 1979. Current staff of 79 solo and small group private practitioners; 87 percent board certified; average age of active staff is 42. University town on unspoiled Lake Superior with all recreational activities. Send curriculum vitae or call: John D. Wojcik, MD, Recruitment Committee, Marquette General Hospital, 420 W. Magnetic Street, Marquette, MI 49855. 906/228-9440, extension 434.

OPHTHALMOLOGIST — Board certified/eligible Ophthalmologist sought to associate in an established practice. Major regional medical center consisting of 43 multi-specialty physicians in Northwest Ohio. Top salary and excellent fringe benefit program along with all corporate benefits. Please forward curriculum vitae, salary requirements to MSMS, 120 W. Saginaw, Box 11, East Lansing, MI 48823.

TROY — PSYCHIATRIST WANTED for a private Out-Pt. Clinic. Bd. eligible or Bd. certified. Multidisciplinary, dynamic and very active practice. Salary dependent upon experience and negotiable. Excellent working conditions and location. Please contact Y. M. Alkar, MD, Medical Director, 2151 Livernois, Troy, MI 48084 or call 313/362-4144.

FIVE-ROOM NEWLY REFURBISHED clinic needs occupancy. Want a full-time, part-time or semi-retired physician. Located in upper peninsula where the air is pure, the water unpolluted and nature is your neighbor. If interested please correspond with Blair Vickerman, Chairman, Medical Committee, Box 27, Grand Marais, MI 49839.

RESIDENT OR PART-TIME PHYSICIAN for Saturday at Family Clinic. Call or write — Trail Clinics, P.C., Cindy Papuga, Clinic Secretary, 313/861-4400, 18254 Livernois, Detroit, MI 48221.

FAMILY PRACTICE — established solo practice in town of 6,000, service area 18,000; located in Northern Lower Michigan; new full service 129-bed hospital; close referral center. This area offers the full range of water sports, large and small game hunting, snow skiing, etc. Contact: David M. Coates, President, Community Memorial Hospital, Cheboygan, MI 49721, Phone: 616/627-5601.

GENERAL INTERNIST, BOARD ELIGIBLE to join with established general internist, private practice. Salary leading to partnership. Northern Oakland Co. Area. Reply to P.O. Box 3276, Pontiac, MI 48059.

MICHIGAN — Active well-established large general practice, general surgery, in desirable recreational area, Northern Michigan. Excellent gross, modern equipment. Clinic bldg. with or without adjoining beautiful large home with lighted tennis court and swimming pool. Will lease or sell one or both. Favorable terms. Contact N. Lentini, MD, Lentini Medical Clinic, PC, 401 Elm Street, Cheboygan, MI 49721, 616/627-5656.

FAMILY PRACTITIONERS, INTERNISTS, and/or OB-GYNs needed in growing, prosperous Dutch community to join a Board Certified family physician in existing practice, or solo available. Excellent economy with medical education, recreational lakes, and ski resorts within 20 mile radius. Will help solo practice to start out. Guarantee net income of $40,000 for first year partner. Call Grand Rapids, MI, 616/531-9803 between 9 and 11 p.m.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park, there are openings for physicians board qualified as internists, family physicians or psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently between forty-five and fifty-five thousand per year, plus 23% fringe benefits, including life, accident, long term disability, dental, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. Liability insurance not necessary. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7830.

Miscellaneous

FOR SALE — CUSTOM-BUILT HOME situated on approximately 40 acres of wooded land, river frontage, trout pond, three bedrooms, two baths. Many extras. An hour's drive north of Bay City. $85,000. 517/345-1571.

MEDICAL OFFICE SPACES available for lease in a newly built office on Hoover Road between Thirteen and Fourteen Mile Roads in Warren, Michigan. Contact: 939-5830.

MEDICAL OFFICE SUITE for rent. New multispecialty building — Suitable for one of two family practice physicians. Contact: F. D. Johnson, MD, 211 Associates, 211 Crapo St., Mt. Pleasant, MI 48858, Phone 517/772-4846.

MICHIGAN PHYSICIANS' Mutual Liability Insurance Company investment certificate for sale. Value $2,000. Selling price $1,900. Contact Gerald L. Davis, MD. 906/786-2607.

ESTABLISHED PROFESSIONAL BUILDING has large suite continuously occupied by physician and recently vacated. Attractively landscaped in residential neighborhood. All utilities and services with ample parking. 3506 Lovers Lane, Kalamazoo. Phone 616/345-6909.

AU SABLE RIVER/NEAR GRAYLING. 1,230-foot frontage with three modern cabins completely furnished. Large cabin sleeps eight. Beautifully wooded property with mature trees. Facilities are ideal for three or four family ownership or as an organizational retreat. Will consider dividing. Land contract terms. Brochure on request. EACO Realty, Box 21203, Lansing, MI 48909. 517/686-5660.

PROFESSIONAL OFFICE FOR LEASE — Prime location in Grandville, a prosperous Dutch community near Grand Rapids. 2725 square feet for group of three doctors. Office can be divided to suit interested party's needs. Call 616/457-2450 between 9 and 5 p.m. or 616/531-9803 from 9 to 11 p.m.

FOR SALE — MPMLC surplus certificate. Basic value $1000. Please call from 1-6 p.m. Monday through Thursday. Phone 313/852-4100.

FOR SALE — 320 Acres — Excellent deer and pat hunting. Located S.W. of Alpena on four county lines — N.E. corner of Oscoda Co. bordered by Alpena, Montmorency and Alcona Cos. The Turtle Lake Club is our neighbor to the north and west. Three buildings — Main sleeping cabin — fireplace and gas propane heat, 1½ car garage. Week days call Bill or Jack, 313/644-0100.

GROUP PRACTICE NEEDED — all new medical center in prime location of Brighton. 2000 square feet office unit, includes four exam rooms or more, private office and entrance, laboratory, excellent parking, ideal to accomodate one or two doctors. Immediate occupancy. Call Davis Professional Bldg., 313/229-2752.

The following list of "reportable diseases" is published here as a reminder to Michigan physicians, at the suggestion of the MSMS Committee on Public and Environmental Health.

Anthrax
Botulism
Cancer
Chickenpox
Cholera
Dengue
Diphtheria
Dysentery, Amebic
Dysentery, Bacillary
Encephalitis, infectious
  Primary
  Secondary
  Undetermined
Epidemic keratoconjunctivitis
Foodborne diseases and food poisonings
Fungus infections, systemic
  Actinomycosis
  Blastomycosis
  Coccidioidomycosis
  Histoplasmosis
  Other (Including severe cutaneous forms with systemic manifestations)
Hepatitis, infectious
Hepatitis, serum
Infectious jaundice (Weil's disease, leptospirosis)
Leprosy
Malaria
Measles
Meningitis, all forms
  Aseptic
  Meningococcal
  Tuberculous
  Other bacterial and unspecified purulent forms
Mumps
Neonatal infections (first 28 days of life)
  Ophthalmia neonatorum (Gonorrheal)
  Diarrhea of newborn
  Staphylococcal disease
Occupation diseases
Pertussis (whooping cough)
Plague
Poliomyelitis
Post partum infections
  Puperperal streptococcic infections
  Staphylococcus disease
Q fever
Rabies (both human and animal)
Rheumatic Fever, acute
Rocy Mountain spotted fever
Rubella (German Measles)
Salmonella infections (except those due to S. Typhi)
Scarlet Fever, and other hemolytic Streptococcal infections of the upper-respiratory tract and erysipelas
Smallpox
Tetanus
Trachoma
Trichinosis
Tuberculosis
Tularemia
Typhoid fever (due to S. Typhi)
Typhus
Undulant fever (Brucellosis)
Veneral diseases
  Chancroid
  Gonorrhea
  Granuloma inguinale
  Lymphagranuloma venereum
  Syphilis
  Yellow fever

Deaths

Walter Belser, MD
Ann Arbor

Walter Belser, MD, Ann Arbor obstetrician, died July 5 at the age of 74. Doctor Belser served as chief of staff at St. Joseph's Mercy Hospital and headed its department of obstetrics and gynecology. He was a fellow of the American College of Surgeons and a diplomate of the American Board of Obstetrics and Gynecology. A graduate of the U-M Medical School, Doctor Belser was a founding member of the American College of Obstetrics and Gynecology. He also was a member of the Michigan Society of Obstetrics and Gynecology and Washtenaw County Gynecologic Society.

Robert H. High, MD
Troy

Robert H. High, MD, Troy, died June 13 at the age of 60. He was a staff physician and former chairman of the pediatrics department at Henry Ford Hospital, Detroit. Doctor High was formerly a member of the staff of St. Christopher's Hospital for Children, Philadelphia. A graduate of Temple University Medical School, Philadelphia, he was an examiner for the American Board of Pediatrics. Doctor High was a member of the American Academy of Pediatrics, the American Board of Pediatrics, the Society for Pediatric Research and the American Pediatric Society.

Edwin M. Hubbard, MD
Benton Harbor

Edward M. Hubbard, MD, 54, former pathologist at Mercy, Memorial and Watervliet hospitals, died July 5. Doctor Hubbard, of Benton Harbor, graduated from Harvard Medical School. He was a staff member at Bronson Hospital, Kalamazoo, in the department of pathology. His society memberships included the College of American Pathologists, Michigan Pathologists Society and International Academy of Pathologists.

President's page

Running Scared

The proponents of change in the health care delivery system seem to be running scared. They seem to be in the midst of a desperate drive for enactment of a national health scheme. They appear to reject efforts to solve specific problems and to be committed to a total program.

Unhappily, the proposed changes cannot solve the fundamental problems of cost containment and the specious issue of access since they propose changes in the organization for health care delivery and not in the basic processes. We physicians cannot ignore what is going on around us, but must become informed, and transmit this information to our patients if we are to do our part in the maintenance of an effective and economically sound pattern of providing for the preventive, diagnostic, therapeutic and supportive health needs of our nation.

It has become apparent to the proponents of change that each passing month makes the enactment of a national health system less likely. The collective actions of these groups would seem to imply that the end is so important that all means of achieving it are justified. Their underlying thesis is that health care costs can't be controlled without a total change in the delivery system. Excessive cost of the system and inequities in access have been cited as the basis for change. The models are the existence of national health systems in all industrialized nations. Data are cited in support of the advantages of one element of one system or another as compared to the American experience, usually utilizing older figures. They usually ignore the fact that the major failures of the present system and the poor proxy indicators of our national health status are failures within the public sector — which also reflects the highest costs. Data to support this are now available and are becoming more generally known.

The basic justification of inequities in access to health care are disappearing. The figures cited in the early and mid-sixties in support of Medicare, Medicaid, and the health component of the War on Poverty were that 20-25 percent of our population were inadequately served or unserved. Estimates by HEW for 1975 reduce this figure to 10 percent, reflecting a 50-60 percent solution of the problem of access in just 10 years without upsetting our health care delivery system.

A paper in the July 1978 issue of *Medical Care* by Ronald Anderson, PhD, and Lu Ann Aday, PhD, of the Center for Health Administration Studies, University of Chicago, assumes the best indicators of access to health care are service to the aged and to the severely ill. A review of data covering the period September 1975-February 1976 compiled by the Center and others revealed no inequity in access for these groups.

"Cost" is interpreted in various ways, including total real cost of a service or program and, at the other end, out-of-pocket cost to whoever pays the bill. Most cost containment efforts address cost transfers — getting someone else to pay the bill, be it the patient, another unit of government, industrial management or anyone at all on whom the donkey tail can be pinned. The error has been made that delegating certain medical duties to less qualified personnel will reduce costs. This assumes that these personnel can do the job equally well in the same time with minimal or no supervision. These assumptions are faulty, represent the thinking of industrially oriented individuals and ignore the published descriptions of how other health professionals see themselves.

The control of cost — the total expenditure for health care — must define what is health care, then address the process, the units produced, or the cost per unit. No fundamental changes in process have been proposed to date.

Louis E. Heideman, MD
MSMS president

So long as it is contended there are underserved and unserved people who are to have the best of care we will continue to increase the units of care. Unit cost has gone up at a rate less than or equal to inflation.

How then are costs to be contained?

We can't sit back and assume the issue will go away. We must review our process and reevaluate the need for all the procedures used. Is it cheaper to order all possible laboratory work you will need initially or to go in a logical order from procedure to procedure depending on the results of the prior examination? How many of our tests are duplications without contributing to understanding or the diagnosis of what is going on in the patient? Are the health resources we are using appropriate to the case?

We must more intensively address the demands and expectations of our patients. There is some dissatisfaction, and some of this is based on reality.

We must become familiar with the strengths and weaknesses of other forms of health care delivery and interpret these to our patients. It takes just ten minutes a day.

Scientific Meeting opening stacked with drawing cards

Because of the large number of excellent courses planned for the 1978 Annual Scientific Meeting at the Detroit Plaza, MSMS program planners have deliberately "stacked the deck" for Tuesday, Nov. 7, the opening day of the three-day meeting.

"We've deliberately scheduled a number of highly popular, high-interest sessions for the first day in an effort to attract physicians who hopefully will be encouraged to enroll for courses all three days," says Robert F. Wilson, MD, program chairman. All courses offer Category I credit.

"By including medical problems like hypertension, diabetes, kidney disease, endocrinology, cancer and basic life support that first day, we cut across many specialty lines and can offer something of interest to a great number of physicians," says Doctor Wilson.

"And then you add to it courses dealing with drug interactions, alcoholism among doctors, care of the elderly patient and a frank look at the subject of coronary bypass surgery, you have a very tempting array of courses to whet the curiosity and medical appetites of Michigan physicians," concludes Doctor Wilson.

Hypertension, diabetes, sex

Among other courses being offered Tuesday morning are: Newer Developments in the Evaluation and Treatment of the Hypertensive Patient"; "Management of Diabetes Mellitus — Problems in Acute and Chronic Care"; "Common Pitfalls in the Management of Malignancies"; "It's Now Easy to Recognize & Manage Chronic Obstructive Pulmonary Disease"; "What's New and Practical in Peripheral Vascular Surgery"; "Sex and the Heart Patient"; and "Basic Cardiac Life Support."

Tuesday afternoon continues the tone established in the morning courses with offerings including: "What's New in Anti-Arthritics, Beta-Blockers, Bronchodilators, Vasodilators — With Special Attention to New Agents and Drug Interactions"; "Alcohol and Medical Practice"; "Care in the September Years"; "Assessment and Management of the Patient with Acute and Chronic Renal Failure"; "Sexuality: New Recognition Or Another Perspective of an Old Subject?"; "Current Trends in Coronary Artery Bypass Graft Surgery"; and "What's New and Practical in Office Endocrinology."

Special note should be made of the fact that "Basic Life Support," a course which has proven extremely popular in the past two Scientific Meetings, is being offered only on Tuesday morning this year. This is being done in the belief that many of the previous course enrollees may now be interested in the "Advanced Cardiac Life Support" course which is being offered as a special 16-hour course running all day Wednesday and Thursday.

One of the unique features of the Tuesday afternoon session is the course dealing with four classes of drugs including anti-arthritics, vasodilators, bronchodilators and beta-blockers. An expert on each will discuss various drugs falling in these classes. In addition, Brian Whiting, MD, senior lecturer in clinical pharmacology at the University of Glasgow, Scotland and one of the developers of MEDISC will be on hand to discuss drug interactions.

Through the courtesy of Upjohn and Parke Davis, a MEDISC will be given to course enrollees. MEDISC, a quick reference wheel enabling the physician to determine possible interactions, reactions, diminished or enhanced effectiveness of various drugs in combination, normally retails for several dollars.

Diversity at reasonable cost

"Put all these courses and features together," concludes Doctor Wilson, "and I think physicians will agree it is difficult to find this kind of quality program with as much diversity under one roof and especially at such reasonable cost."

On Wednesday, November 8, MSMS will offer 25 Category I Courses, and on Thursday, November 9, an additional 19 courses.

Early enrollment is advised since most courses will have maximums based on the room size assigned to them.

ASM topics carefully selected

Do you wonder how courses are selected for the 1978 Annual Scientific Meeting Nov. 7-8-9 at the Detroit Plaza?

The procedure was discussed at a recent meeting of the MSMS Committee for CME Programming. The minutes explain: "Topics are being selected after careful consideration of many documents that help indicate physicians' needs. The ASM leaders have available for study (1) evaluation reports from each 1976 and 1977 course, (2) a summary of a questionnaire which asked 1977 registrants what courses and subjects they would like to have offered in 1978, (3) survey returns from specialty societies and medical school departments indicating what 1976 and 1977 courses should be repeated, (4) information about the various courses offered by the AMA to meet the needs of physicians expressed at various regional levels.

The planners for the Scientific Meeting receive considerable advice from the chairmen of medical school departments and from the education committee chairmen of the many specialty societies. Their ideas for courses are based on surveys which ask specialists what new information they need and want. Planners also consider the five-year CME core curriculum approach being followed by the Michigan and American Academies of Family Physicians.

University of Glasgow pharmacologist heads cast of speakers at Ren Center

Many distinguished medical educators will come from other states and countries to speak at the MSMS Annual Scientific Meeting Nov. 7-8-9 at the Detroit Plaza in the Ren Center.

Many of the course directors are bringing out-of-state authorities to join the outstanding Michigan professors and practitioners for the 58 half-day Category I courses.

Some of the visiting dignitaries are being "introduced" to MSMS members in this article and others will be featured in the October issue.

Among the headliners will be Brian Whiting, MD, senior lecturer in clinical pharmacology at the University of Glasgow, who will be on the faculty for the Tuesday afternoon, Nov. 7 course on "What's New in Anti-Arthritics, Beta-Blockers, Bronchodilators, and Vasodilators." Doctor Whiting is on tour in America visiting several medical schools and was obtained for MSMS by George L. Royer, Jr., MD, Kalamazoo, the course director.

Doctor Whiting reports that "research in my present position is directed at various aspects of clinical pharmacology and the safe and rational use of drugs." He developed the warning system for drug interactions, and a MEDISC quick reference wheel to drug interactions will be given to each doctor registering for the MSMS course.

Coming for the Wednesday morning, Nov. 8 course on "Common Errors in Pediatric Management" will be Lester Baker, MD, professor of pediatrics, University of Pennsylvania School of Medicine. During the past year he has authored articles in national publications about childhood psychiatry, pediatric endocrinology, anorexia nervosa, and hyperinsulinism. He is acting director of the Division of Endocrinology/Diabetes at Children's Hospital in Philadelphia. He will participate in the course planned by Ralph Cash, MD, WSU School of Medicine and CME leader for the Michigan chapter of the American Academy of Pediatrics.

Charles P. Lucas, MD, WSU, course director for "Newer Developments in the Evaluation and Treatment of the Hypertensive Patient" Tuesday morning, Nov. 7, reports that Robert G. Luke, MD, will be one of his presenters. Doctor Luke is professor of medicine and director of the renal division at the University of Kentucky Medical Center. An active researcher and writer, Doctor Luke has an extensive bibliography of 104 entries. In Kentucky, he has been active in movements to improve treatment of kidney diseases.

Doctor O'Connor

Vincent J. O'Connor, Jr., MD, chief of urology at Northwestern Memorial Hospital, will come to Detroit for the course on "Male Sexual Problems: Impotency, Infertility," being planned by Gerald F. Conway, MD, Royal Oak, for the Michigan Branch of the American Urological Society, Wednesday afternoon, Nov. 8. Professor of urology at Northwestern, he is one of the officers now in the Chicago Urological Society. He has been a regular contributor to the Journal of Urology.

Coming from the Mayo Clinic will be Philip E. Bernatz, MD, who is professor of surgery at the Mayo Medical School. He will be the guest expert for the course "Common Problems in Thoracic Surgery," Thursday afternoon, Nov. 9 with Raymond J. Barrett, MD, course director. The course will be sponsored by the Michigan Society of Thoracic Surgeons. Doctor Bernatz specializes in thoracic and cardiovascular surgery.

Another out-of-state speaker will be Irwin M. Arias, MD, vice-chairman and professor of medicine at Albert Einstein Medical School in New York. He will join the faculty being assembled by Keith S. Henley, MD, U-M department of internal medicine, for the Thursday afternoon, Nov. 9 course on "Chronic Non-Alcoholic Liver Disease." At Albert Einstein, he is also director of the liver research center. He has received a number of national and international awards for achievements in gastroenterology.

Doctor Arias

Doctor Baker

Doctor Bernatz

Doctor Luke

Theatres, Meadowbrook Music Festival, opera active during MSMS Scientific Meeting

Physicians and spouses who attend the MSMS Annual Scientific Meeting at the Detroit Plaza Nov. 7-8-9 will have many opportunities to enjoy the very fine restaurants and entertainment spots in Detroit.

Some of the specialty societies will hold banquets during the three-day meeting and the Wayne County Medical Society will present its "Beaumont Lecture" Nov. 7 with all physicians and spouses invited to reserve places.

There are early indications that many physicians who attend CME courses at the MSMS Annual Scientific Meeting Nov. 7-8-9 will bring the spouse along for a mini-vacation. MSMS has had phone calls from physicians asking about special shows and fun in the Detroit area on the same nights as the Scientific Meeting.

The following information is not complete, but will help the physician and spouse begin to make early plans. Mailing addresses and phone numbers are included in this article, so contacts can be made direct for details.

The spectacular Detroit Plaza in the Ren Center contains many restaurants and stores and three movie theatres. Phone 313/568-8000.

In the same area is the Detroit Music Hall (350 Madison Avenue, 48226; Phone 313/963-7680) which will present "Show Boat" by the Michigan Opera Theatre on the three nights of Nov. 7-8-9.

When contacted for this article on Aug. 1, the Fisher Theatre had not firmed up its Fall calendar of plans and play productions.

Some doctors and spouses may want to drive to the Meadow Brook Music Festival during the Scientific Meeting to see the contemporary play "The Championship Season" by Jason Miller. Write to Meadow Brook at Oakland University, Rochester, 48063. Phone 313/377-2010.

Detroit is famous for many great restaurants. Many are close to the Detroit Plaza. The Detroit Convention Center will help make suggestions, 313/259-4333.

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16 hours offered in advanced cardiac life support

For the first time, MSMS and the Michigan Heart Association will offer to physicians at the MSMS Annual Scientific Meeting the complete Advanced Cardiac Life Support Course. The 16-hour course will run eight hours on Wednesday, Nov. 8 and the final eight on Thursday, Nov. 9.

The project will be directed by Daniel T. Anbe, MD, director of cardiac rehabilitation in the Ford Hospital division of cardiovascular medicine.

"The course will be limited to 40 physicians who have completed the CPR course," explains Doctor Anbe. The MSMS Annual Scientific Meeting in 1976 and in 1977 offered the CPR course several times. A three-hour CPR course will be offered Tuesday morning, Nov. 7 for anyone who might want to then complete the advanced course on Wednesday and Thursday.

Physicians must register for the 16-hour approved course before Oct. 10. They will be sent an extensive packet of study materials and instructions. The American Heart Association ACLS texts will be followed. Candidates who successfully complete the testing according to AHA standards will be certified as providers in ACLS by the Michigan Heart Association, explains Doctor Anbe.

The registration form for the Scientific Meeting includes the opportunity for this advanced course. A fee will be charged to cover the costs of study materials, materials for use at the course, and for a special faculty of 13 trained instructors.

Doctor Anbe, the course director, also is a member of the national ACLS faculty.

Beaumont Lecture featuring H.M. Spiro, MD, of Yale University

Howard M. Spiro, MD, distinguished professor of medicine at Yale University, will give the 57th Annual Beaumont Lecture during the Michigan State Medical Society Scientific Meeting in Detroit Nov. 7-8-9, at the Detroit Plaza.

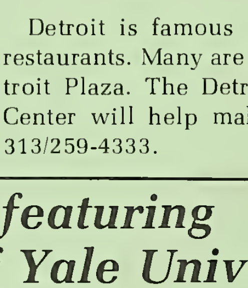
This banquet program will be presented by the Wayne County Medical Society Tuesday night, Nov. 7 at the Plaza in the Ren Center.

"Doctor Spiro was selected because of his extensive research and study about digestive diseases," explains Rosser L. Mainwaring, MD, Dearborn, chairman of the WCMS selection committee.

Doctor Spiro was graduated from the Harvard Medical School in 1947 and joined the Yale medical faculty in 1955. He has been professor of medicine since 1967 and chief of the gastrointestinal section since 1955. He has received many awards at Yale including the medical school "teacher of the year award."

The banquet will be open to all physicians and spouses who attend the 1978 Annual Scientific Meeting. Reservations should be made direct with Roger Mecum, Wayne County Medical Society, 1010 Antietam, Detroit, 48207, 313/963-1640.

Doctor Beaumont



PLEASE SEND ENTIRE PAGE WITH CHECK

1978 Michigan State Medical Society Annual Scientific Meeting Registration Form for Category I CME Courses

* Courses Approved for Prescribed Credit by the American Academy of Family Physicians

TUESDAY MORNING, NOV. 7

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Basic Cardiac Life Support
*_____ Common Pitfalls in the Management of Malignancies
*_____ It's Now Easy to Recognize & Manage Chronic Obstructive Pulmonary Disease
*_____ Management of Diabetes Mellitus — Problems in Acute and Chronic Care
*_____ Newer Developments in the Evaluation and Treatment of the Hypertensive Patient
_____ Sex and the Heart Patient
*_____ What's New and Practical in Peripheral Vascular Surgery

TUESDAY AFTERNOON, NOV. 7

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alcohol and Medical Practice
*_____ Assessment and Management of the Patient with Acute and Chronic Renal Failure
*_____ Care in the September Years
_____ Current Trends in Coronary Artery Bypass Graft Surgery
*_____ Sexuality: New Recognition Or Another Perspective of an Old Subject
*_____ What's New and Practical in Office Endocrinology
*_____ What's New in Anti-Arthritics, Beta-Blockers, Bronchodilators, Vasodilators — With Special Attention to New Agents & Drug Interactions

On Tuesday evening, Wayne County Medical Society will present its Annual Beaumont Lecture at a dinner program. Write to WCMS, 1010 Antietam, Detroit 48207 for details about program and registration.

The courses will provide 3 hours of Category I credit toward the state relicensure requirements and the AMA Physicians Recognition Award.

Please check the courses you wish to attend. In each case please indicate a second choice should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, luncheon tickets, etc., must be picked up at the MSMS Registration Desk upon arrival at the Detroit Plaza.

Physicians must make their own hotel reservations prior to 10/16/78 direct with the Detroit Plaza Hotel, Renaissance Center, Detroit, MI 48243. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Scientific Meeting.

WEDNESDAY MORNING, NOV. 8

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Advanced Cardiac Life Support (A 16-hour course to run all day Nov. 8 and 9. (See tuition below)
*_____ Common Errors in Pediatric Management
*_____ Diagnosis & Treatment of Common Esophageal Disorders
*_____ Diagnosis & Treatment of Patients with Hematologic Disorders
*_____ Diagnosis & Treatment of Pneumonia and Legionnaires' Disease
*_____ Evaluation of the Dizzy Patient for the Family Physician
_____ Lead Poisoning — An Update
*_____ New Concepts in Peptic Ulcer Disease / New Approaches to Obstructive Jaundice
_____ Newer Developments in Diagnosis and Treatment of Neurological Problems
*_____ Office Dermatology for the Non-Dermatologist
*_____ Office Gynecology for Non-Gynecologists
*_____ What's New in Surgery

WEDNESDAY AFTERNOON, NOV. 8

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Congestive Heart Failure — New Concepts in Evaluation and Therapy
*_____ Cost Awareness and Medical Care
*_____ Current Concepts and Management of Common Pediatric Surgical Problems
_____ Current Management of Hemorrhoids, Anal Fissures and Anal Fistulas
_____ Cutaneous Manifestations of Systemic Disease
*_____ Dealing with Women Patients
*_____ Diagnosis and Treatment of Allergy and Bronchial Asthma in Children
*_____ Diagnosis and Treatment of Common Rheumatic Disorders
_____ Identification and Management of the High-Risk Obstetrical Patient
*_____ Male Sexual Problems: Impotency, Infertility
*_____ Nuclear Medicine — Review of Current Applications and New Developments
*_____ Physicians and Their Families
*_____ Poisonings in the Emergency Department

THURSDAY MORNING, NOV. 9

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Diagnosis and Treatment of Common Athletic Injuries
*_____ Diuretic Therapy: Applications and Complications
*_____ Exercise in Medicine: Controversies, Indications Proper Prescribing, and Precautions
*_____ Frequent Problems in ECG Interpretation
_____ Immunology and Inflammatory Bowel Disease
_____ Interpreting the Biochemical Profile
_____ Nosocomial Infections: Recognition and Management
*_____ Role of Hyperalimentation in Common Medical an Surgical Disorders
_____ Scientific Medical Writing
_____ Transplantation: Current Status and Future Prospects

THURSDAY AFTERNOON, NOV. 9

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Antibiotic Therapy — New Advances
*_____ Chronic, Non-Alcoholic Liver Disease
_____ Common Problems in Thoracic Surgery
*_____ Current Concepts in Systemic Diseases and th Macula
*_____ Diagnosis and Treatment of Cardiac Arrhythmias
*_____ Medical Genetics for the Practicing Physician
*_____ Panoramic View of Marital Therapy
_____ Ultrasonic Imaging in Radiology
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Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
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Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
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15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Her next attack of cystitis may require the Bactrim™ 3-system counterattack

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

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Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 27 SEPTEMBER 18, 1978

CAPSULES

RESULTS ARE BEING TABULATED of an MSMS survey of 3,200 members on their group health insurance plans. The survey was just completed by the MSMS Bureau of Economics. It was generated by the MSMS House of Delegates request that alternative group health insurance programs be investigated for the membership. Further details of the survey will follow in a future Medigram.

* * *

AMA LEADERS ARE MAKING APPEARANCES early this fall in Michigan. The executive vice president of the AMA, James Sammons, MD, will speak to members of the Wayne County Medical Society Oct. 10 at WCMS headquarters. AMA Past President John Budd, MD, Ohio, will speak Sept. 26 to Lenawee County Medical Society members. His topic will be "What If There Was No AMA?"

* * *

THE CALL IS GOING OUT for research papers on family medicine for presentation at Michigan's Second Annual Family Practice Research Day on Nov. 2, at MSU. Prospective program participants wishing to present papers are advised to submit abstracts by Sept. 29 to Douglas McKeag, MD, Clinical Center, MSU, East Lansing, 48824, 517/353-0850.

* * *

WORK IS UNDERWAY ON A PLANNED SURVEY of Michigan physicians re the state's medical arbitration system. The Arthur Young and Company contracted

(Continued on page two)

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Planning Support Center will aid MDs in HSA work

Doctors working on health planning at health systems agency level will be supported by MSMS staff and a new informational flow under action taken by The Council Sept. 13. The Council authorized establishment of an MSMS physician/HSA support center. The center will provide backup to doctors who serve on HSA boards, committees, task forces and other groups. Liaison with the State Health Coordinating Council will remain the responsibility of current government agency liaison in the MSMS Division of Government Relations, though there will be close coordination between staffs.

The center will place staffers "in the field" to deal personally with health planning board members and HSA staff, as well as developing in the center's headquarters an information resource center. Major emphasis will go to the Southeast Michigan HSA, but all eight HSAs in Michigan will receive MSMS assistance under Council action.

The center concept was developed by the MSMS Health Planning Steering Group and presented to The Council by Kenneth J. Ray, MD, chairman, who told The Council, "The purpose of the physician/HSA support center will be to advance good health planning in Michigan. MSMS believes it can best achieve this purpose through vigorous, well-informed participation by physicians. It therefore becomes essential for MSMS to provide support for those physicians who participate in the health planning process."

(See related article on Sept. 21 hearing on Prospective State Health Plan, next page.)

Watch for information coming soon on the new MSMS group life open enrollment period . . .

CAPSULES/continued

by the Arbitration Advisory Committee plans to survey hospitals and physicians on their perception of the arbitration system's effectiveness. Arthur Young will gather data in preparation for an arbitration report to the legislature to be made in September, 1979.

* * *

A BIGGER, MORE SOPHISTICATED COMPUTER is in operation at MSMS headquarters now, to better coordinate and move along MSMS membership and related activities. The IBM System 34 is of the third generation, medium-size office type. It has a capability for operation from multiple terminals which can be located in other MSMS offices.

* * *

DONALD KENNEDY, the Food and Drug Administration commissioner, will head speakers for a symposium Tuesday, Oct. 17 at Cobo Hall, Detroit, on products under FDA jurisdiction. The conference, which begins at 8:30 a.m., is being sponsored by the Detroit District office of the FDA, and will include panels on prescription and non-prescription drugs, food labeling, cosmetics, nutrition and participation on government decision-making. Requests for information may be directed to Diane M. Place, Consumer Affairs Officer, FDA, Detroit District, 1560 E. Jefferson, Detroit, 48207.

* * *

(Continued on page three)

SHCC schedules special hearing on draft State Health Plan

The Statewide Health Coordinating Council (SHCC) will hold a special hearing from 7 to 10 p.m. Thursday, Sept. 21 to allow interested individuals and organizations to comment on the draft preliminary State Health Plan. The location for the meeting will be the MSU University Club, 3435 Forest Road, East Lansing. The preliminary SHP has been distributed by the Michigan Office of Health and Medical Affairs. The meeting is being held in advance, and in addition to, public hearings scheduled in late November or early December. Those unable to attend the special session may forward written comments. MSMS members who plan to attend or desire further information may contact OHMA at 517/373-9650, or Sherry Wellman, MSMS headquarters, 517/337-1351.

MSMS files amicus suit in support of Doctor Friedman

MSMS filed Sept. 15 an amicus curiae suit in support of Doctor Seymour Friedman's countersuit appeal to the Supreme Court. Doctor Friedman's litigation is the most prominent of the Michigan attempts to countersue against lawyers who have allegedly filed non-meritorious medical malpractice cases. The MSMS Council on Sept. 13 heard a discussion of the case by Doctor Friedman, his attorney and A. Stewart Kerr, MSMS legal counsel. The MSMS decision to support Doctor Friedman was made in July.

Medicaid payments for abortion autumn battle for legislature

The Legislature returned Sept. 5 for its short September session and immediately received a bill to provide Medicaid funds exclusive of "nontherapeutic" abortions. Governor Milliken had vetoed those parts of the social services appropriations bill that banned payments for abortion services. In so doing he was forced to eliminate line items for all physicians' services, hospital services and pharmaceutical services in the Medicaid program. The new budget takes effect Oct. 1. On Sept. 14, the House Appropriations Committee reported to the floor a substitute for HB 6650 with no proscriptions on abortion. The full House is scheduled to act on the new "clean" bill this week. MSMS is working to support Governor Milliken's position that Medicaid patients would be subject to discrimination under the anti-abortion language.

Specialty societies submitting ideas for UAW contract benefits

Specialty societies, component societies and individual physicians are submitting their written suggestions for discussions of medical benefits to be included in the 1979 auto company/UAW contract talks. The Council of Specialty Societies will meet Sept. 20 to review suggestions made so far. Physician input is being directed by Louis E. Heideman, MD, MSMS president as project chairman, and coordinated by Richard Campau of the MSMS staff. Michigan Blue Cross/Blue Shield in May asked MSMS to serve as a focal point for MDs' suggestions for the medical service programs included in the auto contracts.

Doctor Heideman discusses outlook for NHI

"It has become apparent to the proponents of change that each passing month makes the enactment of a national health system less likely," says MSMS President Louis E. Heideman, MD, in his President's Page article in the September issue of Michigan Medicine. Yet, says Doctor Heideman, physicians cannot sit back and expect the problems of health care delivery to go away. Physicians must become informed about other forms of health care delivery and interpret their strengths and weaknesses to their patients. Further details appear on page 526 of the September Michigan Medicine.

TALKS OF THE PHYSICIAN/BLUE CROSS BLUE SHIELD OF MICHIGAN liaison group are proceeding well, reports Donald K. Crandall, MD, Muskegon, chairman. Doctor Crandall made a progress report to The MSMS Council Sept. 13. He said the essentials in the first phase of negotiations, to implement an effective health care cost containment program, have been worked out. Details remain to be decided upon. Completion of this phase of work hinges on the successful completion of the other three steps, however, which include 1) an effective service benefit program, 2) reimbursement policies supportive of service benefit and cost containment principles, and 3) equal treatment of all physicians within a reimbursement system consistent with the first three principles.

* * *

(Continued on page four)

Are you in joint practice setting?

The MICHIGAN JOINT PRACTICE COMMISSION (MSMS is a member) is seeking to identify physicians and other health professionals currently in joint practice settings. Those identified will be placed in a directory and/or reference listing to allow the MJPC to better correspond with them and include them in conferences. If you are in joint practice and wish to be so identified in the listing, please complete the form below and return to MSMS, 120 W. Saginaw, East Lansing, MI 48823.

Name: ______________________ (Please print) Phone number: ____/__________

Mailing address: ______________________

Type of practice: ____ Family Practice ____ Pediatric ____ Surgical ____ Ob/Gyn
____ ______________ (Other? Please specify)

Practice setting: ____ Private office ____ Hospital ____ Clinic
____ ______________ (Other? Please specify)

I am currently in joint practice with: ______________________

I wish to have my name added to the Michigan Joint Practice listing being developed.

____ Yes ____ No Signature: ______________________

CAPSULES/continued

LET YOURSELF GO...to the 1978 MSMS Scientific Meeting at the Detroit Plaza in the spectacular "Ren Center," Nov. 7-8-9. Earn Category I credits and enjoy a mini-vacation. Special room rates are available. See Sept. 11 green Medigram for program and registration form or telephone MSMS for an extra one, 517/337-1351.

* * *

"HOUSECALL," the popular medical call-in television program on Channel 56, Detroit, will launch its fifth season on the air on Tuesday, Oct. 3, 1978 at 7:30 p.m. Produced in cooperation with MSMS and the Wayne, Oakland and Macomb County Medical Societies, "Housecall" features a panel of three physicians who answer questions called in by the viewing audience. An average of 150 phone calls is received during the half-hour program. More than 100 different physicians have appeared on the series thus far. Medical assistants from the tri-county area chapters provide the question takers handling the phones.

MSMS Council highlights

On Sept. 13, The MSMS Council:

1) Voted to establish an MSMS physician/HSA support center to assist doctors working on health planning at health systems agency level, through staff in th field and a flow of information. (See first page article in this issue.)

2) Endorsed and supported the ballot issue which would raise the statewide legal drinking age from 1 to 21. This will be an issue in the Michigan gener election in November. MSMS will write every legislator about the issue.

3) Approved continued monitoring of MSMS cost containment activities by the MSMS Committee to Coordinate MSMS Activities on Medical Care Costs, chaired by MSMS President Louis E. Heideman, MD. The Counc also will appoint a member of the Michigan Delegati to the AMA to join this MSMS committee.

4) Approved the articles of incorporation for a member service corporate subsidiary of MSMS. The purpose of this corporation is to research and develop new member service activities and programs. The ta exempt status of MSMS limits its activities to projects specifically related to its "purpose" as interpreted by the IRS. Establishment of this corporation will permit expansion of services to MSMS members.

5) Voted to appoint a steering committee of five MDs to take the responsibility for continuing efforts to implement the pooled pension trust program.

6) Approved Practical Guides 3 and 4 on "Discharge Planning" and "Outpatient Surgery," respectively, written by the MSMS Task Force on Medical Care Costs These guidelines will be sent to county medical societies and hospital chiefs of staff.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Managing Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine
Medigram

VOL. 77, NO. 28 OCTOBER 6, 1978

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REGISTER NOW
FOR NOV. 7-8-9
MSMS SCIENTIFIC MEETING

"If you need another copy of the program for the Nov. 7-8-9 MSMS Annual Meeting and a registration form, please phone MSMS and they will be mailed to you." (517/337-1351) That suggestion is made by Carl F. Hammerstrom, MD, chairman of the sponsoring MSMS Committee for CME Programming.

Many early advance registrations have been received already at MSMS for the 58 Category I courses that are set for the three-day meeting at the Detroit Plaza. Physicians and spouses must make their own registrations at the Plaza, and may obtain reduced room rates for being at the MSMS program.

The complete program for the meeting appeared in the Sept. 11 issue of Medigram, which was printed on green paper. More information appeared in the September issue of Michigan Medicine, and more will be printed in the October issue.

MSMS has just received word that Tom E. Nesbitt, MD, president of the AMA, will be part of the faculty for the Tuesday afternoon course on "Cost Awareness and Medical Care." The preliminary program listed James H. Sammons, MD, AMA vice president, who now has a conflict.

Physicians who need Category I credits toward relicensure can earn up to six hours a day or 18 hours over the three days.

Physicians upheld in Michigan Supreme Court ruling

On Oct. 2, as this Medigram was going to press, the Michigan Supreme Court held that the state insurance commissioner cannot disapprove Blue Cross/Blue Shield of Michigan rate increases when such action interferes with the practice of medicine and the physician/patient relationship. The court also specifically held that the insurance commissioner does not have the authority to regulate BCBSM rates of payment to physicians.

The state insurance commissioner in 1975 reduced a BCBSM rate increase request by $46 million because he found the request was based in part on waste in health care costs. The commissioner also rejected BCBSM's proposed increases in physicians' screens as "not justified." Blue Cross/Blue Shield filed suit, contending that the insurance commissioner lacked authority to in effect penalize BCBSM by reducing rate requests for failing to implement cost containment provisions in its health care programs.

MSMS legal counsel filed an extensive brief in the case, pointing out that the actions of the insurance commissioner violated the 1939 Enabling Act which set up the Blues and forbids any health care plans which interfere with or interrupt the physician/patient relationship and the freedom of the patient to select his own physician. MSMS legal counsel also argued the insurance commissioner had no authority to regulate fees paid to physicians by BCBSM.

The Supreme Court agreed with these arguments. The court held that the commissioner was without authority to disapprove rate increases when his actions would have the effect of invading the physician/patient relationship, usurping the physician's control over the practice of medicine or by limiting the subscriber's free choice of hospitals and doctors. It also specifically stated that the commissioner had no authority to approve rates of payment to physicians.

FORMAL ACTION DELAYED ON STATE HEALTH PLAN

As a result of controversy over the 760-page preliminary State Health Plan, as well as its magnitude, the Statewide Health Coordinating Council has postponed formal action on the plan from October to December. The two-month extension will enable the SHCC to benefit from comments at public hearings, scheduled for November, as well as consider possible alternatives to the more controversial sections to be drafted by the SHCC Plan and Policy Development Committee. The Plan and Policy Development Committee has been expanded in order to deal with the plan and has scheduled meetings for 5 p.m. Oct. 19 at the Hospitality Inn and for 9 a.m. to 5 p.m. Oct. 20 at the University Club, both in Lansing. MSMS responses to the preliminary plan are being drafted for approval by the MSMS Steering Committee on Health Planning and will be described in an article planned for the November issue of Michigan Medicine. Representatives of several specialty societies voiced their concerns over the preliminary plan at a special informal hearing requested by MSMS during the SHCC meeting in September.

Medicaid funds okayed after abortion issue separated

Medicaid funds for physicians', hospitals', and pharmacists' services are continuing to flow following last-minute legislative approval of appropriations for those line items to meet the Oct. 1 deadline. Funds for all three were vetoed by Governor Milliken previously, because of stipulations attached to each preventing any of the funds being used to pay for elective abortions. MSMS, in a special news conference Sept. 18 urged the legislature to speedily enact the funds and not to jeopardize services to the poor over "an issue which should be resolved on its own merit." The funding is only supplemental, however, and is to continue three months, ending Dec. 31.

The abortion issue has to be addressed yet and remains one of the most complex problems in recent Michigan politics. The legislature, however, did not want to jeopardize all Medicaid medical services because of it. The Medicaid budget approved by the legislature in the early hours of Sept. 29 avoids immediate confrontation with the governor over abortion financing, but sets up a post-election showdown. Currently, there are no restrictions against use of state funds for abortions.

Special open enrollment now for MSMS group life plans

MSMS has arranged with the Mutual Benefit Life Insurance Company of Newark, NJ, an open enrollment period for the MSMS group life insurance program. This open enrollment period will allow eligible members of MSMS to obtain $25,000 of group term life insurance with a minimum of inconvenience. Watch the next Medigram for full details and enrollment forms.

Michigan State Medical Society
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ELECTIONS '78

national award-winning publication

Michigan Medicine

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OCTOBER 1978

Photo by Mert Scholten

This issue of Michigan Medicine is dedicated to helping the Michigan physician be as well informed as possible when stepping into the voting booth Nov. 7.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

Special section

531 What you should know, Doctor, about the 1978 elections — the candidates, the issues, how the legislature will be rearranged. Application for an absentee ballot, if you're going to the 1978 MSMS Annual Scientific Meeting, appears on page 535.

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ELECTIONS '78

Election primer:

Part one: Legislative turnovers ahead

By Gary Anderson
MSMS Legislative Analyst

Change will be a key word for the 1979-80 Michigan Legislature. With the August primary elections over, it is assured that at least 40 incumbencies will change with the November general elections — a turnover of 27 percent.

In the 110-member House of Representatives, 11 Democrat and 15 Republican incumbents are not seeking re-election. In the 38-member Senate, eight Democrats and six Republicans are not running.

These changes could have significant impact on the medical community and the legislative program of the Michigan State Medical Society. Many of the incumbents who will not be returning are members of committees which are of vital interest to the medical profession. For instance, of primary concern to the MSMS Medicaid Liaison Committee are the losses of Reps. Melvin Larsen and Joseph Young from the House Appropriations Subcommittee on Social Services, and Sens. Earl Nelson and Charles Zollar from the Senate's corollary subcommittee. Only Rep. Raymond Kehres and Sen. Jerry Hart are likely to return to these subcommittees which deal with the Medicaid program and appropriations.

From the parent Appropriations Committees, Gilbert Bursley, John Toepp and Joseph Snyder will not return on the Senate side, along with Nelson and Zollar. Reps. Warren Goemaere, Melvin DeStigter, Peter Kok and Thomas Sharpe join Young and Larsen in leaving the House Appropriations Committee.

Articles on this and the following three pages are designed to better inform Michigan physicians on the coming elections.

The MSMS State Legislation and Regulations Committee has a keen interest in both the House and Senate Judiciary Committees and the House Public Health Committee and the Senate Health Social Services and Retirement Committee. There will be dramatic changes on all these key committees.

Of the current House Judiciary, the chairman and vice chairman will be leaving. Rep. Paul Rosenbaum ran in the August primary for nomination to the U.S. Senate and the vice chairman, Rep. Jackie Vaughn won his bid to succeed Sen. Arthur Cartwright in the Senate. The Judiciary Committee of both the House and Senate considers medical malpractice legislation. Rep. Gil DiNello, also a member of this committee, ran a successful race for his party's nomination to succeed retiring Sen. Joseph Snyder. On the Senate Judiciary Committee, Vice Chairman Sen. Anthony Derezinsky also ran for his party's nomination to the U.S. Senate and will not be returning. Sen. Patrick McCollough, also a member of the Committee, sought the Democratic nomination for governor. A Republican member of the Judiciary Committee, Harold Zeigler, did not seek re-election.

On the House Public Health Committee, majority Vice Chairman Stephen Monsma won his party's nomination to run for the State Senate to succeed John Otterbacher. Otterbacher, chairman of the Senate Health, Social Services and Retirement Committee, ran for his party's nomination for U.S. Senate.

Others who will not be returning because they ran for other offices, retired, or resigned are:

SENATE: Arthur Cartwright (D), Daniel Cooper (D), Gary Byker (R), and Robert Davis (R).

HOUSE: Daisy Elliott (D), George Edwards (D), Stephen Stopczynski (D), Rosetta Ferguson (D), Michael Conlin (R), Kirby Holmes (R), John Mowat (R), Harry Gast (R), Ray Mittan (R), Edgar Fredericks (R), Thomas Holcomb (D), Stanley Powell (R), John Engler (R), Dennis Cawthorne (R), George Prescott (R), and E. Dan Stevens (R).

Changes ahead as incumbents seek other offices

Several state legislative incumbents are seeking other offices in the 1978 general election. Chief among them, of course, is Sen. William Fitzgerald, now the Democratic challenger against William G. Milliken for governor.

Three are seeking seats in the U.S. Congress: Sen. Robert Davis in the 11th district, Rep. Michael Conlin in the 6th, and Rep. Kirby Holmes in the 12 district.

Rep. Mel Larsen is the Republican candidate for secretary of state, opposing Richard Austin.

Of those leaving the State House, four are Republican candidates for the State Senate and three are Democratic candidates for the senate. They are Rep. John Engler in the 36th district, Rep. Ed Fredericks in the 23rd district, Rep. Harry Gast in the 22nd and Rep. John Mowat in the 19th, all Republican, and Rep. Gil DiNello in the 26th district and Rep. Steve Monsma in the 32nd. Rep. Jackie Vaughn already has been elected in a special election in the Fifth district and is a candidate to succeed himself.

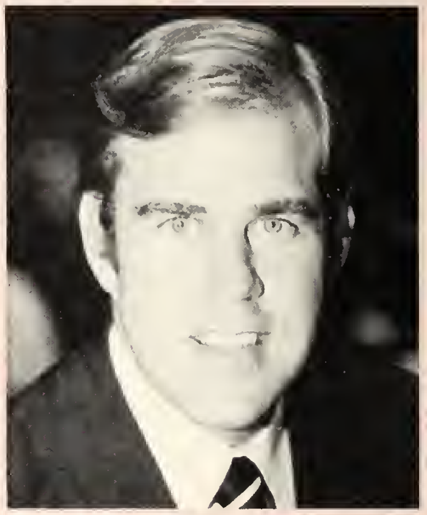
Mr. Anderson

Part two: The candidates

(The following statements were prepared especially for Michigan physicians at the request of *Michigan Medicine*. They are printed here, as they came in, with no revisions.)

For governor of Michigan

Gov. Milliken



Mr. Fitzgerald

William G. Milliken

No area of governmental or public concern is more important than the health of our citizens. High quality treatment by qualified professionals is necessary to maintain health and prevent illness. Government and health professionals must work together to assure access by people to high quality health care services.

Just a few years ago, physicians in Michigan and throughout the nation were faced with a crisis in the availability and high cost of malpractice insurance. Through cooperation among state government, physicians and the legal profession, we were able to pass reforms that today are recognized as a model for the nation. This was an excellent example of the partnership that is needed to improve our health care system.

Another example of what can be achieved through cooperation is the state's new public health code. The code emphasizes the importance of preventive health services and streamlines our public health statutes. It is being hailed as the most significant legislation affecting public health in this century.

The development and passage of the code would not have happened without the strong support and valuable counsel of the state medical society and other groups of health professionals.

We cannot, however, afford to rest on our accomplishments. Together, we must anticipate problems, develop constructive solutions to them, and seek more opportunities to promote health and provide the necessary care to those who are ill. We have the finest physicians and other health professionals in the nation living and working in Michigan. The quality of and access to health care in our state is second to none in the nation. My goal, and your goal, is to maintain that quality and access, and to continue to improve our health care system.

William B. Fitzgerald

I appreciate this chance to address the members of the Michigan State Medical Society in your distinguished journal, *Michigan Medicine*. It is revealing, if not historic, that a portion of your journal would be devoted to a discussion of government.

You should be applauded as a profession for recognizing that government involvement has, in recent years, become a dominant factor in the health care equation. Almost no aspect of our lives is immune to government involvement (or intrusion, if you please). There is little question, however, that the increased role of government is a political response to a public demand. It is important to acknowledge that this demand must recognize, and the response incorporate, the legitimate concerns of the professionals involved.

Looking into the future, we can expect government to continue to play a significant role in the delivery of health care services. How great this role becomes will largely depend upon the attitudes and behavior of the health care professional.

Given the amount of federal, state and local tax dollars flowing into the health care industry, the public's interest in how their money is expended is legitimate. Equally legitimate, however, is the involvement of the professionals in the field.

In reviewing the health legislation recently passed in the Michigan legislature, one must note, and be impressed by, the active role Michigan physicians, and other health care professionals, played in its legislative passage. In the Fitzgerald administration, every effort will be made to include physicians, as well as the consumers of health care services, in development, as well as the implementation and enforcement of state policy. It is only with the active involvement of all affected parties that state policy can reflect the best thinking our society can offer.

For U.S. Senator

Mr. Griffin

Mr. Levin

Robert P. Griffin

One of the most difficult, yet important, challenges confronting us all today — and sure to confront us in the years ahead — is that of assuring Americans quality health care at reasonable costs. This need is particularly urgent in cases of catastrophic illness, which can drain families both financially and emotionally.

While nearly everyone agrees there are deficiencies in our current health care delivery system that must be remedied, there is wide disagreement as to what form that remedy should take.

I believe that in approaching the problems of containing costs while maintaining quality, we must be very circumspect about the role we define for government — because bureaucrats don't have a very good track record in trying to run our lives. Health maintenance is an intensely private matter and should remain so, free from federal meddling that would be sure to follow if national health insurance were enacted along the lines proposed by Senator Kennedy.

But the medical profession and the government can — and must — work together to improve the efficiency of our medical care delivery system, to curb bloated costs, and to develop financial protection for families burdened with the expense of catastrophic illness. In so doing, I believe it is essential that any such system allow patients to use the doctor (and hospital) of their choice. The trust and confidence built into doctor-patient relationships are often as vital to the treatment process as medicines and equipment.

We also must continue federal support for basic and applied research, for training medical personnel, and for helping to provide health care services to rural and inner-city areas now suffering shortages — all programs I long have supported strongly and will continue to support in keeping with the proud tradition of excellence in Michigan's medical community.

Carl Levin

The quality and cost of medical care in the United States is obviously a critical issue. As we confront that issue we must recognize that health care is a matter of both public *and* professional concern. We must balance those two perspectives so that neither one dominates the other. We must recognize the right of all citizens to get adequate health care and the right of professionals to get adequate compensation for their skills and an adequate voice in the determination of the delivery of medical services.

With the context of this "balanced" view, I evaluate specific proposals relating to national health care on three criteria:

1. The program should be comprehensive. It should guarantee that all Americans get adequate health care.

2. The program should be cost effective. Medical care costs have increased by 12 percent between 1976 and 1977. As a share of GNP, medical care costs have increased 65 percent since 1960. This trend can be reversed if we encourage expansion of pre-paid group practice, preventive care, and other delivery system modifications to provide incentives not to use the costly tests and hospitalization unless medically necessary.

3. The program should minimize the need for a new federal bureaucracy. No one knows better than I do how expensive and wasteful the bureaucracy is. While we need to monitor medical care, we need to make sure that regulations don't suffocate and stifle medical care.

MR. FITZGERALD/*continued*

The practice of medicine, and the role of the physician, has changed dramatically over the past 100 years. This change is marked by movement into an age of specialization.

Accompanying this specialization has come the increased utilization of specialists outside of the traditional medical mainstream. Physicians are increasingly relying upon the services of nurse practitioners, physician's assistants, and other well-trained professionals and paraprofessionals.

The acceptance of these health care team members has not been easy for the general public or for the physician. The extent of their acceptance, however, is the direct result of efforts by the Michigan State Medical Society to develop interprofessional relationships. These relationships emphasize the primary role of the physician, a role that I have insisted upon maintaining.

The ultimate benefactor of an excellent medical health care delivery system is the patient. And in Michigan, the patient can expect the highest quality of health care. There is no way to overestimate the importance of maintaining and supporting the highest possible quality health care for all Michigan citizens. It is incumbent upon the medical profession to play an active part in the formulation of public policy to achieve this standard.

Part three: The ballot issues summarized

The Michigan electorate will decide not only the fate of political candidates, ranging from the Governor to local political officers, but also constitutional issues Nov. 7. Following are analyses of those proposals, with identifying letters as they will appear on the ballot:

The ballot proposals seeking to limit taxation, which are of high interest in this election, are described in greater detail, as is the proposal to raise the legal drinking age to 21, which is supported and endorsed by the MSMS Council.

Proposal A — Would call a constitutional convention.

Proposal B — Would prohibit the granting of a parole to a prisoner convicted of certain crimes involving violence or injury to person or property until at least after the minimum sentence has been served.

Proposal C — Would permit the deposit of state funds in savings and loan associations and credit unions as well as in banks.

Proposal D — Would prohibit alcoholic beverages from being sold to, or possessed for purposes of personal consumption by, a person under the age of 21. The MSMS Council has approved and endorsed this proposal.

The proposed amendment would: (1) Define an alcoholic beverage, (2) Prohibit sale or giving of an alcoholic beverage to a person under the age of 21, and (3) Prohibit the possession for personal consumption of an alcoholic beverage by a person under the age of 21.

Proposal E — Would limit taxes.

The proposed amendment, also called "The Headlee Amendment," would:

1. Limit all state taxes and revenues, excepting federal aid, to their current proportion of total state personal income and to provide for exception for a declared emergency.

2. Prohibit local government from adding new or increasing existing taxes without voter approval.

3. Prohibit the state from adopting new or expanding present local programs without full state funding.

4. Prohibit the state from reducing existing level of aid to local governments, taken as a group.

5. Require voter approval of certain bonded indebtedness.

Proposal G — Would allow collective bargaining with binding arbitration for Michigan State Police troopers.

Proposal H — Would prohibit the use of property taxes for school operating expenses and establish a voucher system for financing education of students at public and nonpublic schools.

The proposed amendment, also called "the voucher plan," would:

1. Prohibit the use of property taxes for school operating expenses.

2. Require the legislature to establish a program of general state taxation for support of schools.

3. Require the legislature to provide for the issuance of an educational voucher to be applied toward financing a student's education at a public or nonpublic school of the student's, parent's or guardian's choice.

Proposal J — Would reduce property tax assessments; establish a maximum of 5.6% on the rate of the state income tax; prohibit legislature from requiring new or expanded local programs without state funding; and allow school income tax with voter approval.

The proposed amendment, also called "the Tisch Amendment," would:

1. Reduce real and personal property tax assessments to 25% of true cash value of property;

2. Limit state equalization increase to 2.5% for any year.

3. Establish a maximum of 5.6% on the rate of the state income tax.

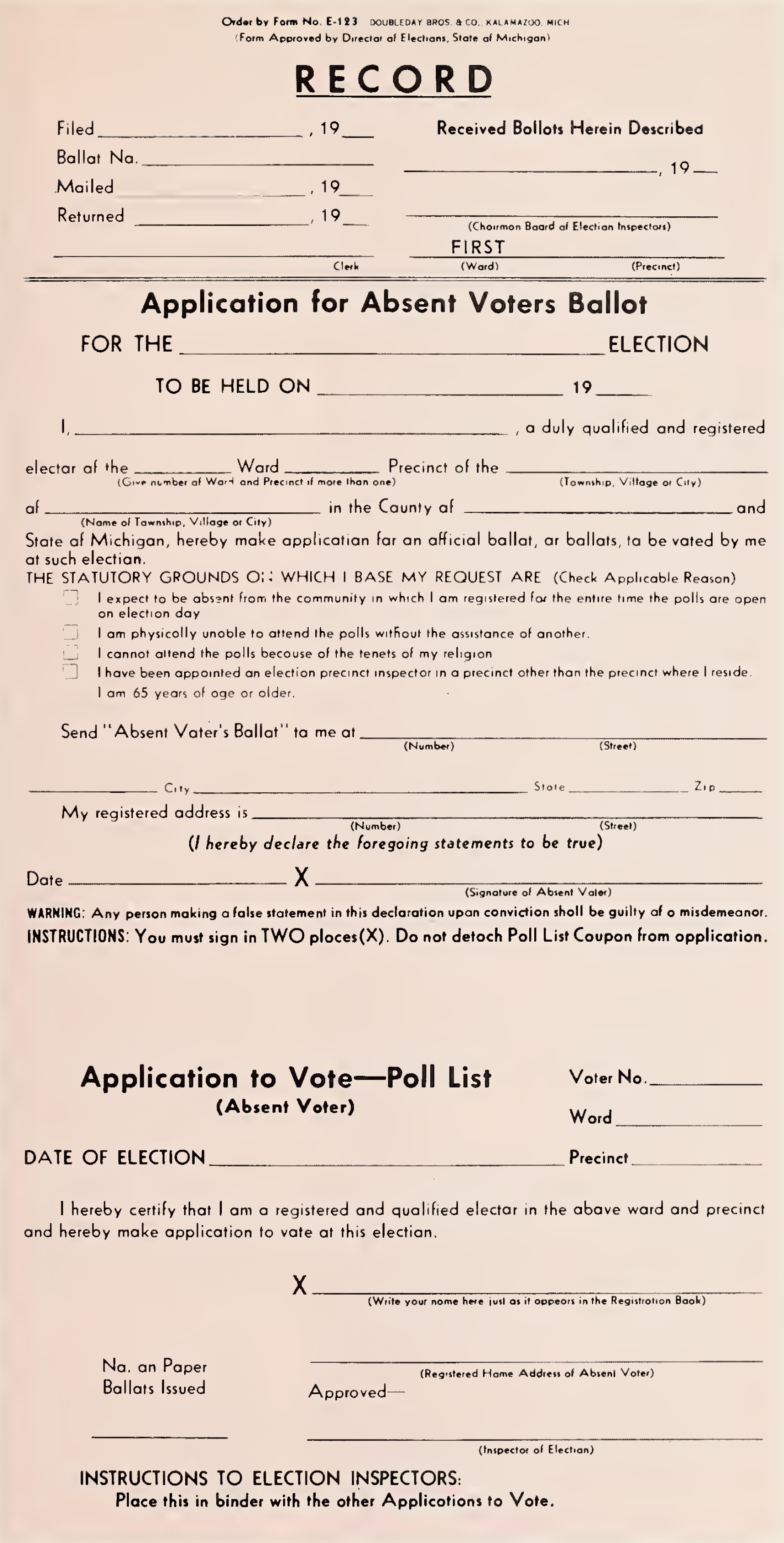
4. Allow the legislature to authorize school districts to levy up to 1% income tax with local school district voter approval.

5. Prohibit legislature from requiring new or expanded local programs unless fully funded by state.

Proposal K — Would grant authority to courts to deny bail under certain circumstances involving violent crimes.

Proposal M — Would allocate at least 90% of gas tax revenues for general road purposes and the remainder for other transportation purposes, and would replace state highway commission with a transportation commission.

Proposal R — Would authorize creation of a railroad redevelopment authority to make loans to railroads with trackage in Michigan and would authorize authority to issue general obligation bonds in amount not to exceed 175 million dollars.



Order by Form No. E-123 DOUBLEDAY BROS. & CO., KALAMAZOO, MICH
(Form Approved by Director of Elections, State of Michigan)

RECORD

Filed ____________________, 19___
Ballot No. ____________________
Mailed ____________________, 19___
Returned ____________________, 19___
____________________ Clerk

Received Ballots Herein Described
____________________, 19___
____________________ (Chairman Board of Election Inspectors)
FIRST (Ward) ______ (Precinct)

Application for Absent Voters Ballot

FOR THE ____________________ ELECTION

TO BE HELD ON ____________________ 19___

I, ____________________, a duly qualified and registered elector of the ______ Ward ______ Precinct of the ____________________ (Give number of Ward and Precinct if more than one) (Township, Village or City) of ____________________ (Name of Township, Village or City) in the County of ____________________ and State of Michigan, hereby make application for an official ballot, or ballots, to be voted by me at such election.

THE STATUTORY GROUNDS ON WHICH I BASE MY REQUEST ARE (Check Applicable Reason)

☐ I expect to be absent from the community in which I am registered for the entire time the polls are open on election day
☐ I am physically unable to attend the polls without the assistance of another.
☐ I cannot attend the polls because of the tenets of my religion
☐ I have been appointed an election precinct inspector in a precinct other than the precinct where I reside.
I am 65 years of age or older.

Send "Absent Voter's Ballot" to me at ____________________ (Number) (Street)
______ City ______ State ______ Zip ______
My registered address is ____________________ (Number) (Street)

(I hereby declare the foregoing statements to be true)

Date ____________________ X ____________________ (Signature of Absent Voter)

WARNING: Any person making a false statement in this declaration upon conviction shall be guilty of a misdemeanor.
INSTRUCTIONS: You must sign in TWO places (X). Do not detach Poll List Coupon from application.

Application to Vote—Poll List

(Absent Voter)

Voter No. ______
Ward ______
DATE OF ELECTION ____________________ Precinct ______

I hereby certify that I am a registered and qualified elector in the above ward and precinct and hereby make application to vote at this election.

X ____________________ (Write your name here just as it appears in the Registration Book)

No. on Paper Ballots Issued ______

____________________ (Registered Home Address of Absent Voter)
Approved— ____________________ (Inspector of Election)

INSTRUCTIONS TO ELECTION INSPECTORS:
Place this in binder with the other Applications to Vote.

Deadline Nov. 4

Fill out this form to apply for absentee ballot

The Michigan absentee voters' ballot application is presented here as a service to MSMS members.

Many physicians will be attending the 1978 MSMS Annual Scientific Meeting Nov. 7-9 in Detroit, and for other reasons will not be at home on election day.

MSMS members may fill out this form and take it to their city or township clerk's office to apply for an absentee ballot. The deadline for applying is Nov. 4.

MSMS members also may wish to duplicate this form and place copies of it in their office waiting rooms as an aid to patients and others who enter the office.

THE MESSAGE OF TENSION
HEADACHES
SWEATS
TENSE, TAUT MUSCLES
HYPERVENTILATION
TACHYCARDIA
PALPITATIONS
BURNING IN STOMACH
FULLNESS
FREQUENCY
to relieve psychic tension
and its functional symptoms
VALIUM®
(diazepam) ⓘⓥ
2-mg, 5-mg, 10-mg scored tablets

VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia,

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
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Nutley, New Jersey 07110

MSMS Scientific Meeting Nov. 7-8-9 offers wealth of courses, speakers, activities

By Herb Auer
MSMS deputy director

Remember shaking a kaleidoscope and watching the variety of designs and color combinations?

The program for the 1978 MSMS Annual Scientific Meeting at the Detroit Plaza November 7-8-9 is much like a kaleidoscope.

As you look at the pages of the program (printed in Sept. 11 issue of *Medigram*) you notice varied Category I CME thrusts.

As you think about the facilities and the extra events you see different aspects of the total projects.

Practical courses offered

Let's continue with the kaleidoscope theme, shake the Scientific Meeting program and look at the subjects . . . courses on drug interactions, sessions on sexuality, the latest on family practice and pediatric problems, a host of courses for the internist. And then there are courses on such challenging general topics as geriatrics, alcoholism, poisonings, cancer management, sports-medicine, genetics.

Another shake of the kaleidoscope will reveal courses to help in everyday practice, to help in the management of diabetes, renal failure, pneumonia, peptic ulcer, systemic disease, rheumatic disorders, and others. And some of the colorful courses will deal with newer developments in the care of hypertensive patients, or the child with bronchial asthma, or the high-risk obstetrical patient, or the patient with marital problems.

New subjects this year

If a physician wants to shake the Scientific Meeting kaleidoscope to find new subjects not offered before, she or he will focus in on cost awareness, physicians and their families, scientific medical writing, and a 16-hour course in Advanced Cardiac Life Support.

For something special, MSMS will spotlight the Wayne County Medical Society Beaumont Lecture Tuesday night, Nov. 7 when Howard M. Spiro, MD, will come from Yale University.

Noted Michigan speakers

If the kaleidoscope were loaded with the names of the speakers instead of pretty pieces of colored glass, the doctor looking through it would see such Michigan speakers as Doctors Ron Krome, Charles Lucas, Jeremiah Turcotte, Dan Anbe, V. K. Vaitkevicius, the team of Petrini and Petrilli, and Sanford Cohen. And another shake would reveal these Michigan physicians on the program: Ken Krabbenhoft, Ken Wilcox, Tom Chapel, Gilbert Mayor, Martin Lerner, Dan English, Bertram Pitt, Ben Lucchesi, Helen Papaioanou, John A. Anderson, and Giles G. Bole. Another quick look at the Michigan speakers includes Doctors Charles J. Berger, Jerry O'Connor, Alan Done, Noel Rose, Dan Marks, Natalia Tanner, Keith Henley and many, many, many others.

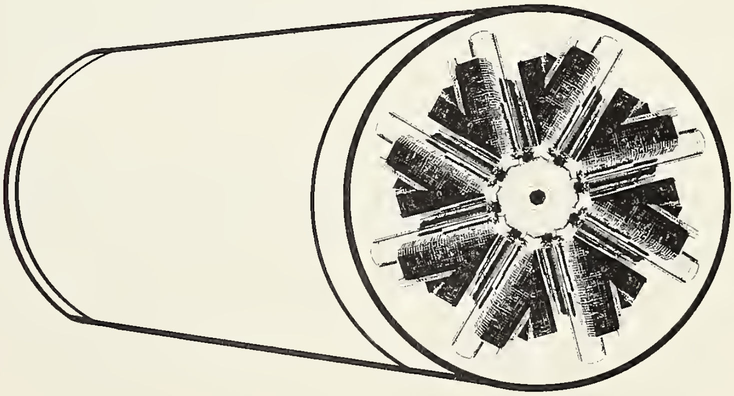
Many authorities coming

If the kaleidoscope were pointed at the names of some of the visiting dignitaries coming to speak, one would identify Arias of Albert Einstein College, Baker of Cook County General, Chester of Case-Western Reserve, Luke of Kentucky, Hofsten of Washington University, Jones of Emery, Scherbel of the Cleveland Clinic, Braverman of Yale, Howard of Children's Hospital in Washington, D.C., and Mead of Creighton.

At least two international figures would be in the spotlight — Doctor Brian Whiting, a clinical pharmacology expert from the University of Glasgow and Doctor John G. Howells, a family therapist visiting from England.

Some new approaches

It is impossible to see every scene flashing in the kaleidoscope, but maybe one can be described as typical of many new features this coming fall. The residents-in-training across the state have been invited to write an essay offering ideas on medical cost awareness. The Michigan Association for Medical Education and essay chairman Gary Welsh, MD, of William Beaumont Hospital, Royal



The author of this article, MSMS Deputy Director Herb Auer has the staff responsibility for the Annual Scientific Program, with Wayne Burmeister responsible for arrangements with the Detroit Plaza. All 31 MSMS employees are involved in this large CME project.

ASM/*continued*

Out-of-state speakers bring expertise to MSMS courses

Many of the half-day courses offered at the MSMS Annual Scientific Meeting, Nov. 7-8-9 at the Detroit Plaza will feature an out-of-state medical authority as has been the pattern in recent years.

Some out-of-state authorities were introduced in the September issue of *Michigan Medicine*, and several more are spotlighted here. There is not sufficient space to print the photos and biographic information about each of the visiting dignitaries.

Edward H. Chester, MD, associate professor of medicine at Case Western Reserve at Cleveland, will join the faculty for the course Tuesday morning, Nov. 7, "It's Now Easy to Recognize and Manage Chronic Obstructive Pulmonary Disease." John G. Weg, MD, U-M professor of internal medicine, course director, reports Doctor Chester will discuss "Practical Rehabilitation" and call upon his experience as chief of the pulmonary division of the VA hospital in Cleveland. A graduate of New York University College of Medicine, Doctor Chester has held positions in the Cleveland Chest Society and the American Thoracic Society.

The same course will also feature Thomas L. Petty, MD, professor of medicine and head of the University of Colorado School of Medicine's division of pulmonary sciences. He will discuss early recognition of chronic obstructive pulmonary disease. A graduate of the Colorado medical school, he has written extensively and is on the editorial board of five medical publications.

The course Thursday afternoon, Nov. 9 "Antibiotic Therapy — New Advances," will feature John P. Phair, MD, professor of internal medicine and director of the Division of Infectious Disease at Northwestern Medical School. Course Director Carol A. Kauffman, MD, U-M and VA Hospital in Ann Arbor, reports Doctor Phair will discuss "Penicillin Allergy — Evaluation and Alternate Antibiotic Therapy." Doctor Phair, a graduate of University of Cincinnati College of Medicine, was a visiting fellow several years ago in the University of Sheffield Medical School's Department of Medical Microbiology. More than 50 of his scientific articles have appeared in medical journals.

James W. West, MD, assistant professor of psychiatry at Rush-Presbyterian St. Luke's Medical Center in Chicago, will be the first speaker at the course Tuesday afternoon on "Alcohol and Medical Practice." Doctor West is chairman of the Illinois State Medical Society panel for the impaired physician and lecturer in psychiatry at the University of Chicago. He was invited to Detroit by Russell F. Smith, MD, Brighton, chairman of the MSMS Committee to Assist Impaired Physicians and the course director.

The Thursday morning, Nov. 9 course on "Immunology and Inflammatory Bowel Disease" will highlight Eugene Winkelman, MD, attending physician in the Cleveland Clinic Department of Gastroenterology. He will lecture on "Therapeutic Principles in the Management of Inflammatory Bowel Disease," according to the course director, Manuel Sklar, MD, Detroit. Doctor Winkelman, a graduate of the University of Michigan Medical School, was chairman of the medical staff at the Cleveland Clinic in 1976 and is serving now as chairman of the Patient Care Committee.

(More articles on ASM follow on page 541.)

Doctor Petty

Doctor Phair

Doctor West

Doctor Winkelman

ASM WEALTH/*continued*

Oak, will judge the entries and the two winning papers will be read by the residents as part of the special Nov. 8 afternoon course on "Cost Awareness and Medical Care."

Preparations moving well

The story of the kaleidoscope would not be complete without shaking it good and recognizing the fitting patterns of the MSMS staff operations . . . registrations going smoothly, attractive educational exhibits, handouts for the various courses, staff assistants in every course, meaningful evaluation forms, and let's not forget free coffee and beer breaks.

Hundreds of hours of work have gone into the project — by the able course directors, by many cooperating specialty societies, by the three medical school faculties, by the speakers who are making final preparations, by General Chairman Robert F. Wilson, MD, by the MSMS CME Programming Committee, by hotel personnel, and by MSMS staffers.

The Plaza is spectacular

The newer kaleidoscopes permit the child (and adult, too!) to look at some landscape or some building and to see it reflected by many times in spectacular designs. A kaleidoscope at the Detroit Plaza hotel in the handsome Ren Center would show the attractive dining rooms, large nearby parking areas, bubbling fountains, hundreds of mum plants, unique shops, and hundreds of hotel employees to assist you. The Scientific Meeting registration area will be on the third level with all courses and classrooms on the fourth and fifth levels.

one of today's trends
in oral contraception . . .

stepping down estrogen levels to 50 mcg?

100
mcg estrogen
50
mcg estrogen

Do you have patients currently taking oral contraceptives containing 100 mcg of estrogen for contraception? A switch to a 50 mcg product may be desirable.§

Prospective and retrospective studies indicate a relationship between estrogen doses and serious adverse side effects. ". . .preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism. . ."† The incidence of these side effects decreases as the dosage of estrogen decreases to 50 mcg, as demonstrated in British studies.†

†See Prescribing Information.

a step in the right direction

Ortho-Novum 1/50

TRADEMARK

21 and 28-day regimens

Each yellow tablet contains 1 mg norethindrone and 0.05 mg mestranol.
Each green tablet in the 28-day regimen contains inert ingredients.

§Serious as well as minor side effects have been reported with the use of oral contraceptives. These include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

See the complete Prescribing Information for this product, a summary of which is on the next page.

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OJ 1291

ORTHO-NOVUM* Tablets

IMPORTANT NOTE—This information is a BRIEF SUMMARY of the complete prescribing information provided with the product and therefore should not be used as the basis for prescribing the product. This summary was prepared by deleting from the complete prescribing information certain text, tables, and references. The physician should be thoroughly familiar with the complete prescribing information and patient information before prescribing the product.

INDICATION: CONTRACEPTION. The pregnancy rate in women using conventional combination oral contraceptives (containing 35 mcg or more of ethinyl estradiol or 50 mcg or more of mestranol) is generally reported as less than one pregnancy per 100 woman-years of use. Slightly higher rates (somewhat more than one pregnancy per 100 woman-years of use) are reported for some combination products containing 35 mcg or less of ethinyl estradiol, and rates on the order of three pregnancies per 100 woman-years are reported for the progestogen-only oral contraceptives. Table 1 gives ranges of pregnancy rates reported in the literature for other means of contraception. The efficacy of these means of contraception (except the IUD) depends upon the degree of adherence to the method.
Table 1: Pregnancies Per 100 Women-Years. IUD, less than 1-6; Diaphragm with spermicidal product (creams or jellies), 2-20; Condom, 3-36; Aerosol foams, 2-29; Jellies and creams, 4-36; Periodic abstinence (rhythm) all types, less than 1-47; 1. Calendar method, 14-47; 2. Temperature method, 1-20; 3. Temperature method—intercourse only in postovulatory phase, less than 1-7; 4. Mucus method, 1-25; No contraception, 60-80. **DOSE-RELATED RISK OF THROMBOEMBOLISM FROM ORAL CONTRACEPTIVES:** Two studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. For this reason, it is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive product prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance. It is recommended that new acceptors of oral contraceptives be started on preparations containing .05 mg or less of estrogen
CONTRAINDICATIONS: Oral contraceptives should not be used in women with any of the following conditions: 1. Thrombophlebitis or thromboembolic disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS

> **Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.**
> **The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.**

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely than nonusers to develop these diseases without evident cause. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age. **CEREBROVASCULAR DISORDERS:** In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4.0 to 9.5 times greater in users than in nonusers.
MYOCARDIAL INFARCTION: An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. In terms of relative risk, it has been estimated that oral contraceptive users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are also smokers have about a 5-fold increased risk of fatal infarction compared to users who do not smoke, but about a 10-to 12-fold increased risk compared to nonusers who do not smoke. Furthermore, the amount of smoking is also an important factor. In determining the importance of these relative risks, however, the baseline rates for various age groups must be given serious consideration. The importance of other predisposing conditions mentioned above in determining relative and absolute risks has not as yet been quantified; it is quite likely that the same synergistic action exists, but perhaps to a lesser extent. **Risk of Dose:** In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Careful epidemiological studies to determine the degree of thromboembolic risk associated with progestogen-only oral contraceptives have not been performed. Cases of thromboembolic disease have been reported in women using these products, and they should not be presumed to be free of excess risk. The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. **ESTIMATE OF EXCESS MORTALITY FROM CIRCULATORY DISEASES:** A large prospective study carried out in the United Kingdom estimated the mortality rate per 100,000 women per year from diseases of the circulatory system for users and nonusers of oral contraceptives according to age, smoking habits, and duration of use. The overall excess death rate annually from circulatory diseases for oral contraceptive users was estimated to be 20 per 100,000 (ages 15-34—5/100,000; ages 35-44—33/100,000; ages 45-49—140/100,000), the risk being concentrated in older women, in those with a long duration of use, and in cigarette smokers. It was not possible, however, to examine the interrelationships of age, smoking, and duration of use, nor to compare the effects of continuous versus intermittent use. Although the study showed a 10-fold increase in death due to circulatory diseases in users for five or more years, all of these deaths occurred in women 35 or older. Until larger numbers of women under 35 with continuous use for five or more years are available, it is not possible to assess the magnitude of the relative risk for this younger age group. This study reports that the increased risk of circulatory diseases may persist after the pill is discontinued. Another study published at the same time confirms a previously reported increase of mortality in pill users from cardiovascular disease. The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. The findings of this analysis are shown in Figure 1 below. The study concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke. (The rates given for pill only/smokers for each age group are for smokers as a class. For "heavy" smokers [more than 15 cigarettes a day], the rates given would be about double; for "light" smokers [less than 15 cigarettes a day], about 50 percent.) The mortality associated with oral contraceptive use in nonsmokers over 40 is higher than with any other method of contraception in that age group. The lowest mortality is associated with the condom or diaphragm backed up by early abortion. The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia and especially by cigarette smoking The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended. Based on the data currently available, the following chart gives a gross estimate of the risk of death from circulatory disorders associated with the use of oral contraceptives:

SMOKING HABITS AND OTHER PREDISPOSING CONDITIONS—RISK ASSOCIATED WITH USE OF ORAL CONTRACEPTIVES

Age	Below 30	30-39	40+	
Heavy smokers	C	B	A	A—Use associated with very high risk.
Light smokers	D	C	B	B—Use associated with high risk.
Nonsmokers (no predisposing conditions)	D	C,D	C	C—Use associated with moderate risk.
Nonsmokers (other predisposing conditions)	C	C,B	B,A	D—Use associated with low risk

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately. A four- to six-fold increased risk of postsurgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization. 2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures. 3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. Certain synthetic progestogens, none currently contained in oral contraceptives, have been noted to increase the incidence of mammary nodules, benign and malignant, in dogs. In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. Of the cases found in women without predisposing risk factors for adenocarcinoma of the endometrium (e.g., irregular bleeding at the time oral contraceptives were first given, polycystic ovaries), nearly all occurred in women who had used a sequential oral contraceptive. These products are no longer marketed. No evidence has been reported suggesting an increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives. Several studies have found no increases in breast cancer in women taking oral contraceptives or estrogens. One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in the subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented. In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

Figure 1. Estimated annual number of deaths associated with control of fertility and no control per 100,000 nonsterile women, by regimen of control and age of woman.

	15-19	20-24	25-29	30-34	35-39	40-44
No method	5.5	5.2	7.1	14.0	19.3	21.9
Abortion only	2.3	2.5	2.5	5.2	9.8	6.6
Pill only-nonsmokers	1.3	1.4	1.4	2.2	4.5	3.1
Pill only-smokers	1.5	1.6	1.6	10.8	13.4	58.9
IUDs only	1.1	1.2	1.2	1.4	1.6	1.4
Traditional contraception only	1.1	1.4	1.9	3.7	4.7	4.0
Traditional contraception and abortion	0.3	0.4	0.4	0.8	1.4	0.B

4 HEPATIC TUMORS. Benign hepatic adenomas have been found to be associated with the use of oral contraceptives. One study showed that oral contraceptive formulations with high hormonal potency were associated with a higher risk than lower potency formulations. Although benign, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives. Two studies relate risk with duration of use of the contraceptive, the risk being much greater after four or more years of oral contraceptive use. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass or shock. A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time. 5. USE IN OR IMMEDIATELY PRECEDING PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated to be on the order of 1 to 4 in 1000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Male children so exposed may develop abnormalities of the urogenital tract. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes. An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of sex hormones, including oral contraceptives, in pregnancy. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 five births. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend three months although no precise information is available on which to base this recommendation. The administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy. 6. GALLBLADDER DISEASE. Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives and estrogens. In one study, an increased risk appeared after two years of use and doubled after four or five years of use. In one of the other studies, an increased risk was apparent between six and twelve months of use. 7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives. An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives. B. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives. Hypertension that develops as a result of taking oral contraceptives usually returns to normal after discontinuing the drug. 9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause. 10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. If pathology has been excluded, time or a change to another formulation may solve the problem. Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease. Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods. Postuse anovulation, possibly prolonged, may also occur in women without previous irregularities. 11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. 12. BREAST FEEDING. Oral contraceptives given in the postpartum period may interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The effects, if any, on the breast-fed child have not been determined. If feasible, the use of oral contraceptives should be deferred until the infant has been weaned. **PRECAUTIONS: General:** 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug-related. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, asthma, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. B Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives: a. Increased sulfobromophthalein retention. b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. c. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered. d. Decreased pregnanediol excretion. e. Reduced response to metyrapone test. **INFORMATION FOR THE PATIENT; (See Patient Package Insert). DRUG INTERACTIONS:** Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. **CARCINOGENESIS, PREGNANCY, NURSING MOTHERS: See CONTRAINDICATIONS and WARNINGS. ADVERSE REACTIONS:** An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS): Thrombophlebitis. Pulmonary embolism. Coronary thrombosis. Cerebral thrombosis. Cerebral hemorrhage. Hypertension. Gallbladder disease. Liver tumors. Congenital anomalies. There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: Mesenteric thrombosis. Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis. The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug-related: Nausea, usually the most common adverse reaction. Vomiting, occurs in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally. Gastrointestinal symptoms (such as abdominal cramps and bloating). Breakthrough bleeding. Spotting. Change in menstrual flow. Dysmenorrhea. Amenorrhea during and after treatment. Temporary infertility after discontinuance of treatment. Edema. Chloasma or melasma which may persist. Breast changes: tenderness, enlargement, and secretion. Change in weight (increase or decrease). Change in cervical erosion and cervical secretion. Possible diminution in lactation when given immediately postpartum. Cholestatic jaundice. Migraine. Increase in size of uterine leiomyomata. Rash (allergic). Mental depression. Reduced tolerance to carbohydrates. Vaginal candidiasis. Change in corneal curvature (steepening). Intolerance to contact lenses. The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted: Premenstrual-like syndrome. Cataracts. Changes in libido. Chorea. Changes in appetite. Cystitis-like syndrome. Headache. Nervousness. Dizziness. Hirsutism. Loss of scalp hair. Erythema multiforme. Erythema nodosum. Hemorrhagic eruption. Vaginitis. Porphyria. Impaired renal function. (ORTHO-NOVUM 1/50□21 and ORTHO-NOVUM 1/50□2B contain tartrazine. Allergic reactions have been reported with the ingestion of this dye in some patients.) **ACUTE OVERDOSE:** Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

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Long-time ASM exhibitors to be honored

An important adjunct to the Annual Scientific Meeting is the large exhibition area where physicians have an opportunity to view the latest in equipment, new medications and office machinery and systems.

The 1978 meeting will offer attendees a wide range of exhibits as 63 firms will be displaying information and products related to health care. These exhibits will provide the physician an opportunity to discuss drugs, office systems, laboratory services and procedures without interruption from patient, staff or telephone.

As a special feature this year, 22 firms will be specially recognized for their long-standing support of the MSMS Scientific Meeting. Watch for the special recognition certificate in each of the booths occupied by those exhibitors who have been part of the MSMS meeting for 25 years or more.

Attendees will be able to browse through book displays to select a helpful textbook on their way to a free coffee break, or update their awareness of insurance options at the end of the day during the beer bust. Prior to or after lunch in the exhibit hall, physicians will be able to discuss the latest drugs or even find out about a career as a military doctor if they're so inclined.

A printed description of each exhibit will be provided in the final program enabling each participant to select the firms which will provide the kind of information or contacts most valuable.

Twenty-two industries who exhibit at the MSMS Annual Scientific Meeting will receive certificates of appreciation from MSMS this November for their continuing support of MSMS over more than 25 years.

Not only have these firms contributed knowledge for the individual physicians of Michigan but also they have contributed financially to the budgets for the meetings.

The MSMS Annual Scientific Meeting has benefited from the participation of these exhibitors for periods ranging from 26 to 43 years.

MSMS points out that MSMS records only go back 43 years but several of these firms report they have been participating for almost 60 years.

The MSMS award will be displayed by these firms at their exhibits so MSMS members can voice their personal appreciation.

The firms, in alphabetical order, are:

Ames Division, Miles Laboratories, Inc.	28 years
Blue Cross and Blue Shield of Michigan	37 years
CIBA Pharmaceutical Company	34 years
Encyclopaedia Britannica	22 years
Ferndale Laboratories, Inc.	41 years
Geigy Pharmaceuticals	26 years
Gerber Products Company	43 years
Hack Shoe Company	33 years
Lederle Laboratories	43 years
Eli Lilly and Company	40 years
Mead Johnson	42 years
Medical Protective Company	43 years
Merck Sharp & Dohme	34 years
Parke, Davis & Company	42 years
Roche Laboratories	29 years
Sandoz Pharmaceuticals	28 years
W. B. Saunders Company	43 years
Schering Corporation	34 years
Smith Kline and French Laboratories	40 years
Stuart Pharmaceuticals	23 years
Tutag Pharmaceuticals	23 years
The Upjohn Company	27 years

1878 MSMS Annual Meeting in Lansing

One hundred years ago, the annual meeting of the Michigan State Medical Society was held in Lansing and the major scientific paper was about "The Legal Relations of Insane Patients," presented by Foster Pratt, MD, of Kalamazoo.

Other medical papers dealt with "Varicose Ulcers" by O. B. Campbell, MD, of Ovid; "Medical Education of the People — Their Best Safeguard" by T. N. Reynolds, MD, Detroit; "Small Pox Epidemic at Dearbornville" by S. P. Duffield, MD, Dearborn; "Scarlatina" by Henry Carstens, MD, Detroit; "Astenopia" by Eugene Smith, MD, Detroit; "The Use of Obstetric Forceps in Country Practice" by G. W. Topping, MD, DeWitt; "Herpetic and Eczematous Eruptions in the Etiology of Chronic Nasal Catarrh" by E. L. Shurly, MD, Detroit; "Suppurative Inflammation of the Middle Ear" by Eugene Smith, MD, Detroit; and "On the Prevention of Delay in Some Presentations of the Breech," by A. F. Kinne, MD, Ypsilanti.

During the meeting in Lansing, the physicians toured the new Capitol building that was just being completed.

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brand of sterile
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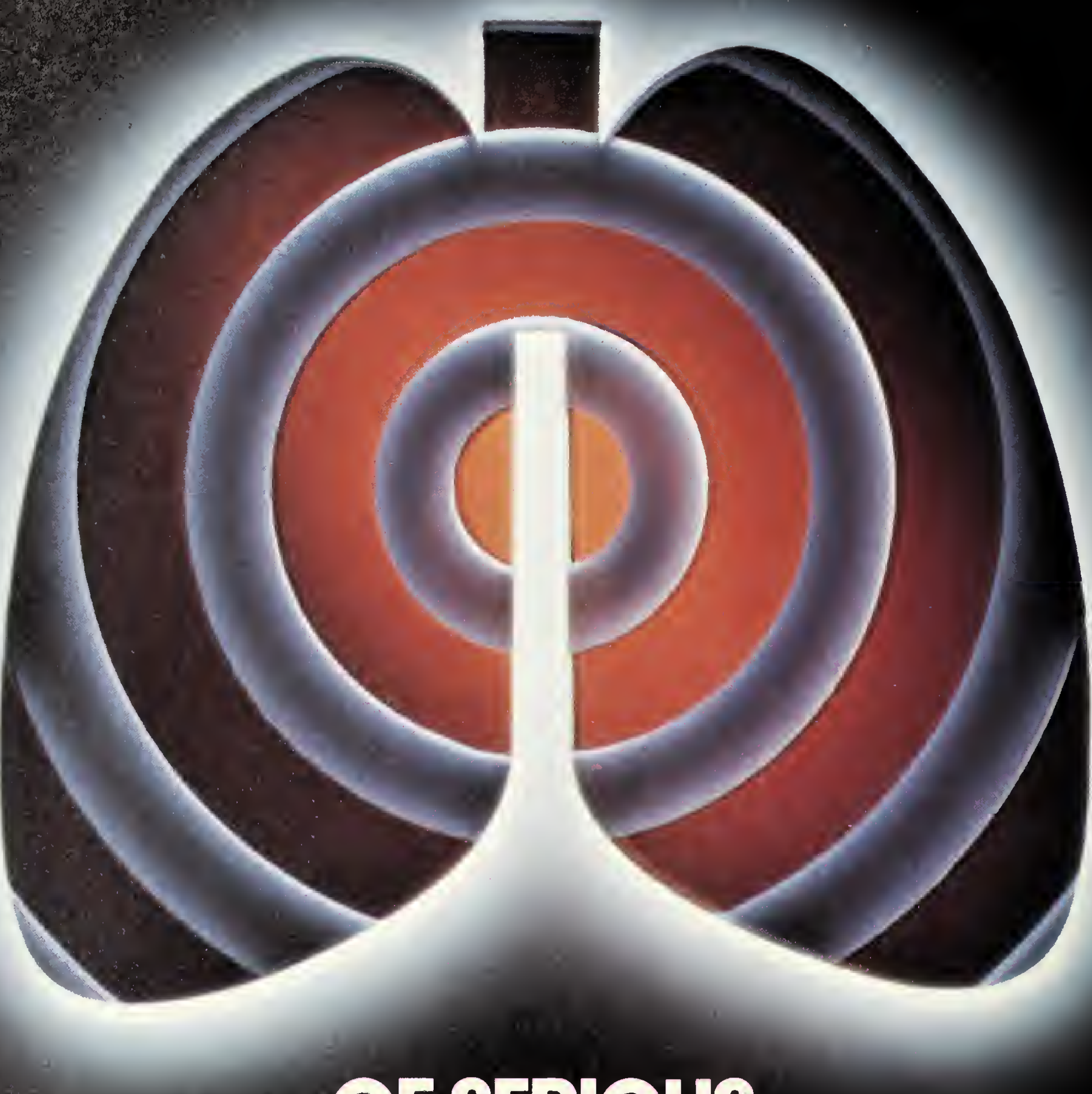
GETS TO THE SITE



OF SERIOUS
RESPIRATORY INFECTIONS

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported: Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. Blood: Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred. Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Gastrointestinal: Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported. Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM
brand of sterile
CEFAZOLIN SODIUM
(LYOPHILIZED)
Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline &French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

WHAT'S IN A NAME?

Anyone who has given this classical question much thought will usually agree that our names carry much meaning and importance. The international recognition and reputation that is attached to such names as Salk, Fiedler and Kissinger was attained by years of hard work and success.

Advance Medical & Research Center, Inc. of Pontiac, in its fifteen years of service to Michigan Physicians, has gained a reputation of high quality and dependability for the clinical laboratory services it provides.

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MSMS adopted these 12 MSMS principles, responsibilities, rights

Principles

1. Medicine is the trustee of society in the care of the sick and injured; its policies must always be governed by this fundamental fact.

2. The good of society must be the sole aim of its public policies and the good of the patient the first consideration in the relations between physicians and patients.

3. Medicine's first responsibility must be to see that its services are available to all men.

4. The public interest demands the most competent medical profession possible. Medicine must be an attractive profession to compete successfully with other professions for the ablest young men.

5. In the sense that every calling from which a living must be gained is a business, medicine is a business; it must accept the competitive conditions of practical life but, as a profession of high ideals, it must seek to prevent selfish commercialism.

6. Experience has shown that the vast majority of disease conditions afflicting man can be most satisfactorily and economically diagnosed and treated by a competent individual general practitioner.

Responsibilities

7. The services of medicine include (a) the practice of medicine; (b) the promotion of preventive medicine and the public health; (c) the fostering of research and the increase of knowledge.

8. Medicine's chief concern must be for the individual physician; the service rendered by individual physicians in the aggregate constitutes the great bulk of medical service. The quality of service which is given depends on the competency of the individual physician who gives it.

Rights

9. The medical profession asks for its practitioners: freedom of opportunity to develop to the limit of their individual capacities.

10. It asks a career of independence under conditions of free and dignified competition.

11. It asks remuneration sufficient for reasonable comfort for the individual and for his family.

12. In its ideals of independence, medicine has a right to control its own affairs. Its history of capacity and altruism justifies this claim.

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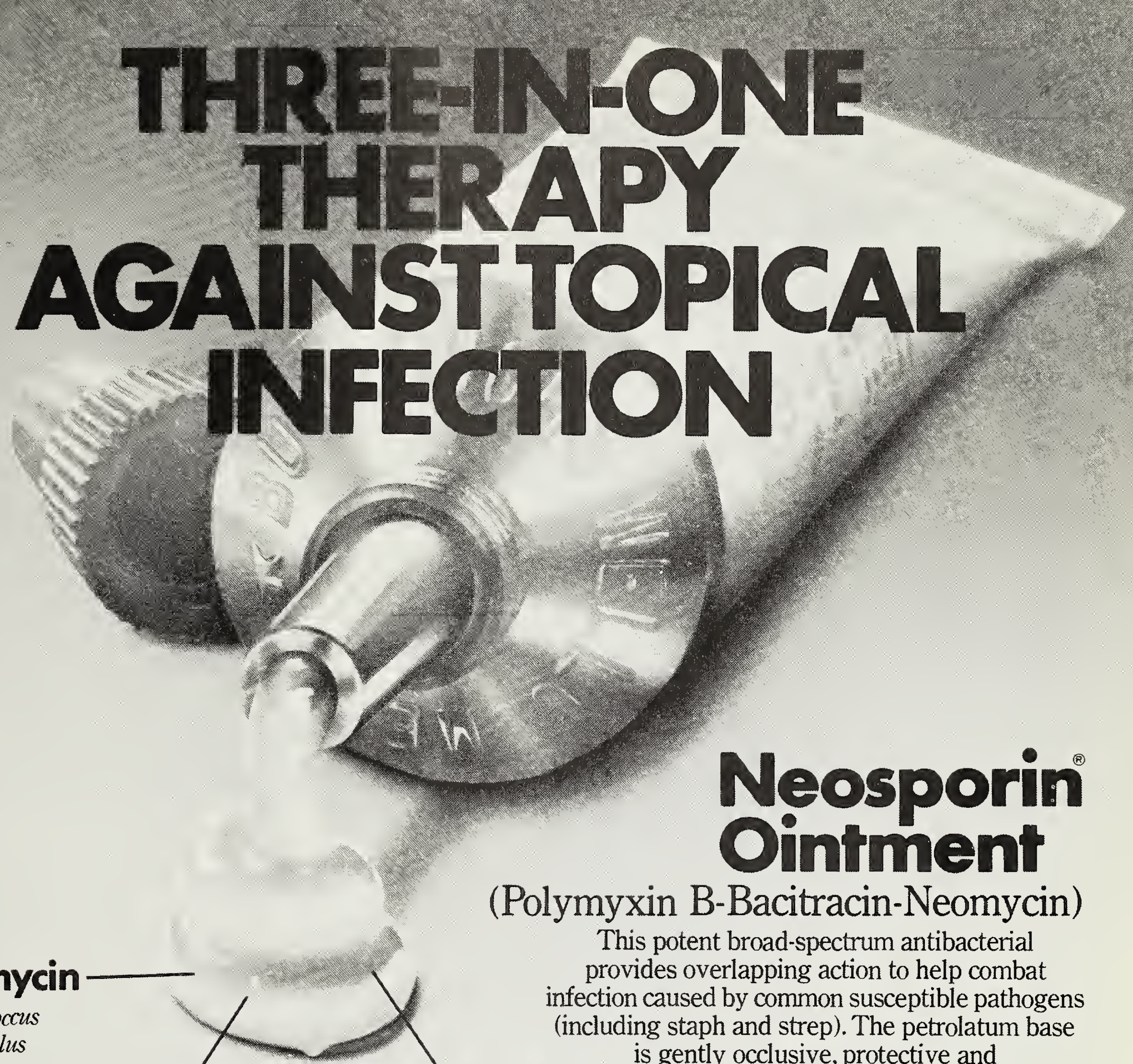

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

Doctor Wilson

FOR: John R. Wilson, MD, President
Michigan Medical Practice Board

"Did the Medical Practice Board act to ban the complete use of amphetamines? If not, what written commentary is needed on medical records if a doctor decides to prescribe amphetamines?"

No, the Medical Practice Board did not act to ban the complete use of amphetamines. It, did, however, promulgate detailed rules and regulations on the prescription of amphetamines. The rules and regulations prohibit drugs from being dispensed except according to the rules, and warn of amphetamines' habit-forming potential. They declare amphetamines shall not be dispensed or prescribed for the treatment of obesity unless other therapies have been found ineffective, and only after minimal requirements have been met. These requirements include a complete physical history, prescription of a diet, daily dosage not exceeding 15 milligrams, no more than a 30-day supply dispensed, and careful monitoring of the patient's progress.

A prescription for the drugs shall indicate whether the purpose is for the treatment of obesity, narcolepsy, hyperactivity or another purpose which the board has authorized by written waiver.

Mr. Fishman

FOR: Herman Fishman, Chief Deputy Director
Michigan Department of Licensing and Regulations

"You recently told an MSMS committee the next group which might be certified or licensed would be 'myofunctional therapists.' Would you please explain what this occupation is?"

Myo-functional therapy is a health-related occupation that was identified by the Legislature in the recent enactment of the Public Health Code. The legislature directed the Health Occupations Council, an advisory group, to study the field of myo-functional therapy and determine the appropriateness of recommending that individuals engaged in this field be licensed or registered. This study is to be accomplished by Sept. 30, 1980. Myo-functional therapy is a treatment for individuals who have difficulty in controlling the normal movement of the tongue. The profession of dentistry, particularly orthodontics, has recognized the need for myo-functional therapy.

Ms. Zemach

For: Rita Zemach, director, Michigan Cooperative
Health Information System

"What is the average age of MDs in Michigan?"

Using data from the Michigan Cooperative Health Information System on licensed health occupations, the average age of active MDs in Michigan may be calculated as 47.5 years. Information from the same source for active DOs indicates an average age of 45.8 years.

A comparison can also be made between the MCHIS data and MSMS data on the age distribution of its members. Both sets of data are for 1976:

Age (years)	*MSMS Members**	*Licensed MDs in Michigan***
25-34	5.9%	16.1%
35-44	28.0	26.5
45-54	30.6	26.7
55-65	20.6	17.6
Over 65	14.9	13.4

**MSMS Bureau of Economics*
***Michigan Cooperative Health Information System*

Auxilians hear advice for better communications

By Willah Weddon
President, MSMS-A

Realistic advice on building better relations with local newspapers was given to MSMS-Auxiliary members by Frank Hand, veteran newspaperman and state editor of the Lansing State Journal, during a "Communication" seminar.

"Make it a habit to telephone in news items or mail in topics for possible feature stories," Hand told the women gathered in Mt. Pleasant for a two-day meeting, Sept. 26 and 27. "Some may not be used, but your ideas will be appreciated. We're always looking for good stories of general interest."

Workshops involving auxiliary interests: AMA-ERF, legislation, international health, community health, family living, MDPAC, membership, leadership and the Project Bank, were conducted by MSMS-A chairmen during this meeting of Districts IV through IX. A slide presentation, "Highlights of University Research," was presented by Louis Graff of the University of Michigan and talks were given by staff members of Central Michigan University.

Mrs. Hoyt Gardner, AMA-Auxiliary first vice-president and wife of the AMA president-elect, will speak and conduct workshops at a similar meeting scheduled Oct. 18-19, in Marshall, for Districts I through III. Other highlights of the program include: Mrs. Fleming A. Barbour, showing slides of health teams working abroad; a speaker from Michigan State University's Institute for Family and Child Study; tours of historic homes in Marshall; an evening with "Lashes," Mrs. Philip Watterson, Coldwater auxiliary member who is a professional clown.

Twelve auxilians will attend the annual AMA-A sponsored "Confluence," a leadership training session, in Chicago, Oct. 25-27. They will hear Tom E. Nesbitt, MD, AMA president; James H. Sammons, MD, AMA executive vice president and Mrs. Manuel A. Bergnes, AMA-A president. Seminars in leadership and educational topics will be provided during the increasingly popular event. Attending from Michigan will be Mrs. Edward R. Weddon, MSMS-A president; Mrs. Dean P. Carron, MSMS-A

Michigan Medicine is pleased to add Auxiliary information to our regular columns. Mrs. S. A. Yannitelli, 28 Woodmer Lane, Battle Creek, 49017, MSMS-A communications chairman, welcomes any questions and urges physicians to take copies of _Michigan Medicine_ home to their spouses.

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MSMS/A/*continued*

president-elect and 10 county presidents-elect: Mrs. Alan Weitenberner (Macomb); Mrs. Allen Turcke (Genesee); Mrs. Robert E. Brantley (Ingham); Mrs. Frank M. Steele (Kalamazoo); Mrs. Thomas Schwaderer (Kent); Mrs. Frank W. Prust (Oakland); Mrs. Richard Wilcox (Muskegon); Mrs. Jack C. Griffith (Calhoun); Mrs. George Maniaci (Gladstone), and Mrs. James Cooper (Bay-Arenac-Iosco).

The AMA-A pays transportation cost to and from Chicago and MSMS-A has allotted $50 toward the $52.50 registration fee. The purpose? To provide auxiliary leaders with background to enable them to better promote the objectives of the medical profession.

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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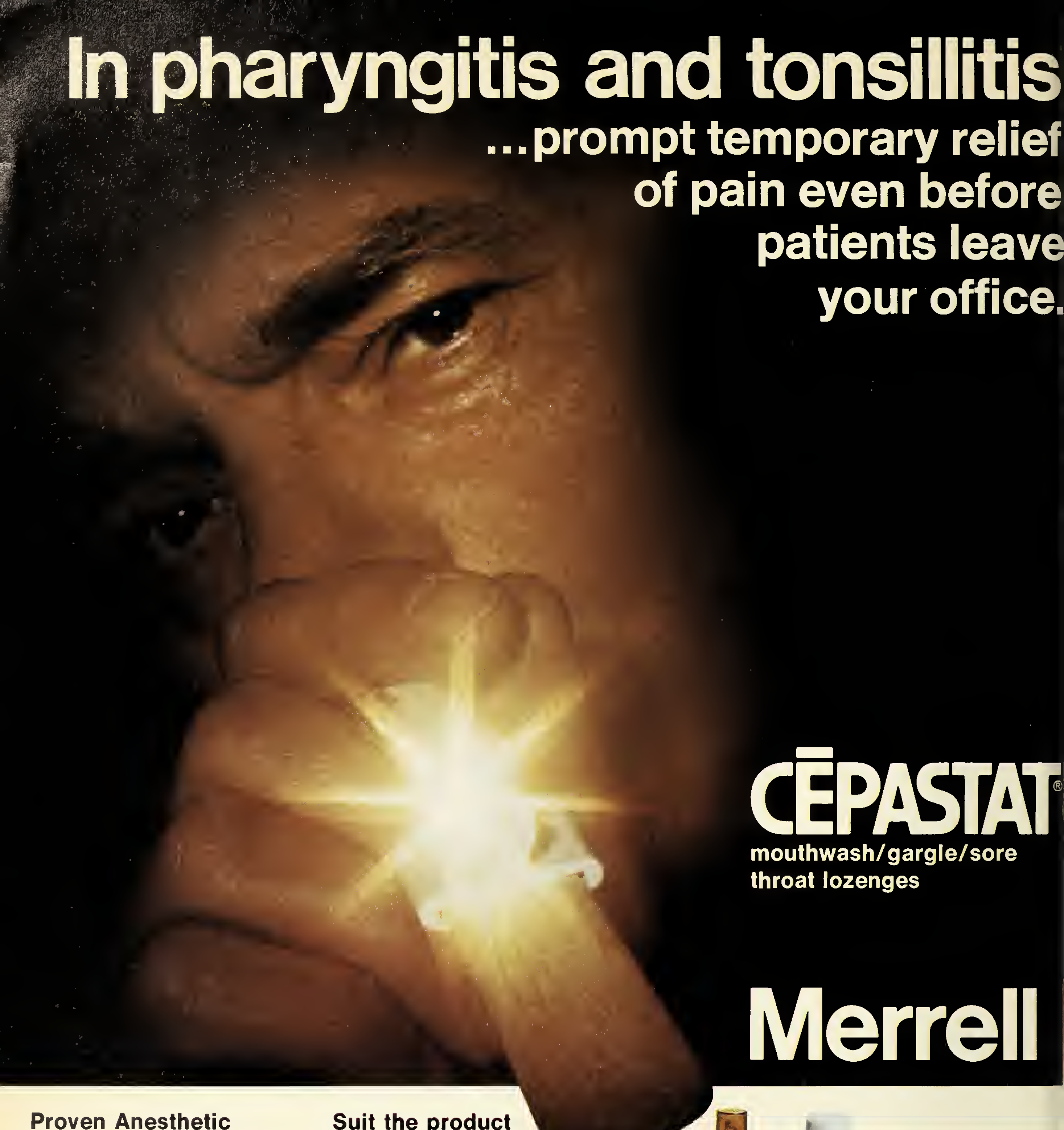

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OCMS review of lab arrangements strengthens medical care delivery in that county

By C. R. Shelton
Special to **Michigan Medicine**

The Oakland County Medical Society, Michigan's second largest county society, has been involved in discussions regarding possible abuses of laboratory utilization by some of the county's physicians for several years.

Their discussions have led to an exhaustive study of the situation and to passage of new ethical guidelines which should be of interest to all Michigan physicians. These developments are detailed here.

Discussions became urgent in January when the Society's monthly publication "The Bulletin" printed a "working paper" entitled "A Kick-back Is a Kick-back."

The "working paper," written by Joel I. Hamburger, MD, was submitted by the OCMS Ad Hoc Lab Committee to the society's board of directors for consideration at their Dec. 6, 1977 meeting. In turn, the Board decided to publish the paper for members' information and consideration of an accompanying motion — about the possible transmittal of it to the Michigan State Medical Society and the American Medical Association for prompt incorporation into the ethical rulings of those organizations.

Kickbacks on agenda

According to Edward E. Elder, Jr., MD, OCMS president, the paper created a great deal of interest and kickbacks were an item on the society's board meeting agendas for seven consecutive months.

Those discussions led to a general membership meeting April 26, where the AMA Judicial Council Rulings on laboratory utilization were read. During deliberations that evening, it became apparent that members were in agreement that ethical rulings of the AMA and MSMS make the acceptance of inducements for referral of laboratory work unethical. What appeared to remain in question was if the payment of dividends to laboratory stockholders (physicians and/or their children) is something other than inducements. Both sides of that question were explored and the group agreed to a motion requesting the ethics committee to review existing OCMS ethical guidelines, propose any changes or additions they felt necessary and report to the Society.

Three new guidelines

In August, Ethics Committee Chairman Walter J. Zimmerman, MD, reported the committee had adopted three additional (to those already in use) "guidelines," proposed by Doctor Hamburger, with regard to utilization of laboratory services by physicians.

Those guidelines state:

(a) Physicians should limit the source of professional income to medical services actually rendered by them or under their supervision to their patients;

(b) It is unethical for a physician to offer or accept any inducement for referrals of patients or specimens from patients for diagnostic assay;

(c) Inducements are unethical whether paid directly or indirectly (e.g., as corporate dividends) and whether related or unrelated to the volume of referrals.

The guidelines were unanimously approved by the Board of Directors.

Doctor Zimmerman further reported that his committee also supported a Resolution from the MSMS House of Delegates Meeting of May, 1978. That resolution states: "Resolved: That the House of Delegates request component medical societies to investigate, where possible, laboratory ownership arrangements within their boundaries and take immediate action to assure that their physician members are not associated with any laboratory ownership schemes which exploit the patient."

Procedures will be followed

Doctor Zimmerman also pointed out that in the future his committee intends to strictly follow the procedures outlined in the OCMS By-laws as they pertain to the review of complaints, whether from non-members, members, or another committee.

This means any complaint from a non-member will be referred to the Mediation/Claims Review Committee. That committee will then determine if the matter is something to consider. If they wish, the committee can refer the question to the ethics committee for study.

Complaints from OCMS members, or from committees of the Society, first will be referred to the president who will decide which committee should be assigned review of the complaint.

Doctor Elder says the board of directors also approved a motion commending Doctor Zimmerman and his committee for their extensive study of the situation.

"I believe the efforts that our Society has expended on this subject will have far-reaching results, some of which we may never personally know about. Also, I am sure the delivery of health care in our county will continue to be among the best. And, hopefully, very ethical in all respects."

Michigan men advise world medical meeting

Doctor and Mrs. Tommy N. Evans, Detroit (left) and Mr. and Mrs. Warren Tryloff, MSMS director, are shown at a reception in Chandos House, the historic residence of the Royal Society of Medicine located in London's Mayfair district. Doctor Evans served as program advisor and Mr. Tryloff as North American consultant to the world medical meeting, Advances in Medicine, which was sponsored by the Royal Society of Medicine, and held in London in July. Representatives of 36 nations attended the week-long meeting, including six delegates from the Republic of China.

WSU search begun for new vice president of health affairs

New Wayne State University President Thomas N. Bonner has created the office of vice president for Health Affairs and appointed Martin Barr, PhD, as the acting vice president for health affairs. Barr has been serving as secretary to the university's board of governors.

In making the appointment, President Bonner moved "to assure everyone of my strong commitment to the development of health care programs at Wayne State."

While naming Doctor Barr, President Bonner talked of the special importance of "the success of the multi-disciplinary, ambulatory, primary-care concepts and other programs embodied in the Health Care Institute, as well as the important relationships with the other institutions comprising the Detroit Medical Center.

A national search has begun for a permanent vice president for Health Affairs.

WSU establishes MD practice plan for clinical services

The Wayne State University Board of Governors has adopted a "University Physicians Practice Plan" which provides a system for setting the fees paid to physicians for patient services in the Health Care Institute/ Wayne State University Clinics.

The 16-page document, which is the culmination of six years of study and development, does not itself establish fees. Rather, the plan defines the mechanism for the collection of fees from private patients visiting the Clinics and dividing the payments among the physicians participating in the plan.

The plan establishes a Michigan corporation which allows the physician to "run their own business" in the Clinics Building.

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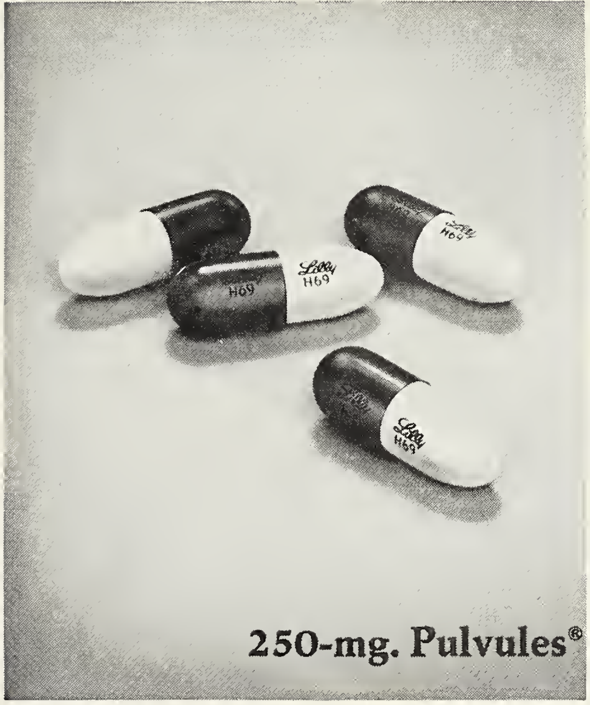

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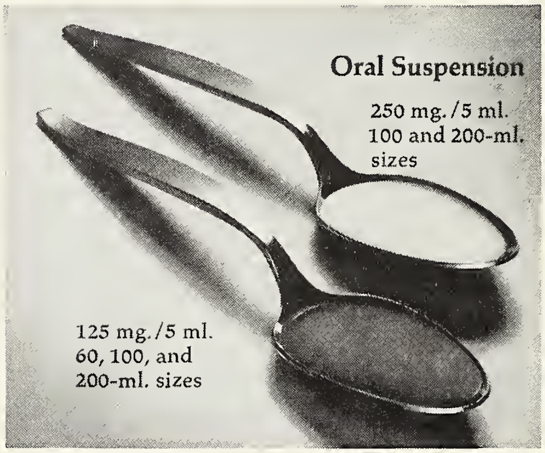

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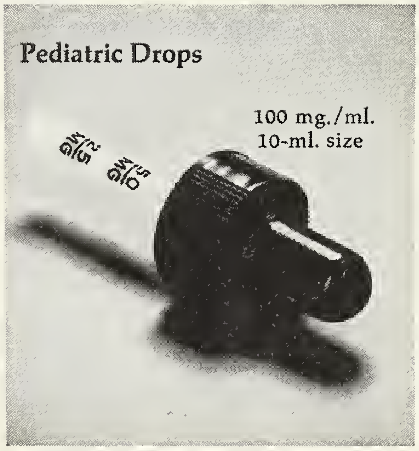

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News

Ann Arbor physicians **Ronald** and **Nancy Bishop** are rapidly building a medical dynasty. Two of their children, Ellen and David, graduated from the U-M Medical School this spring. But that is only the beginning. Other doctors in the family are Nancy Bishop's sister, Joan Rider, MD, and her husband Claude Trapp, MD, of Lexington, Kentucky; Paul Arkema, MD, a Boston psychiatrist is married to the Bishop's other daughter, Christine (who has a PhD in medical economics); and Mark Young, MD, Ellen's husband who also graduated this year from the U-M. That makes eight doctors in one family! Can anyone top that record?

* * * * * * *

What better way to get away from the pressures of a busy medical practice than to set sail on Lake Huron with 268 other yachts in a race to Mackinac Island? That's what **Michael Papo, MD**, of Chelsea, did this summer on his yawl, the Pappillion. Two of his colleagues, James Botsford, MD, and Donald Demcheff, MD, helped crew.

* * * * * * *

If the open seas don't appeal to you, you might want to follow the lead of **Virgilio Bonet, MD**, of Grand Blanc, who has found relaxation in raising Arabian horses on his 117-acre farm. Doctor Bonet developed his fondness for horses in his native Columbia, and his enthusiasm has been caught by his wife and three children who all lend a hand in the family enterprise.

* * * * * * *

Still others choose entirely different hobbies. Grand Rapids physician **Robert D. Burton** traveled to Deya, a tiny village on Majorca, this summer to pursue his interest in archaeology, where he joined a dig team at an excavation site believed to be rich in fossils and artifacts of an ancient Mediterranean civilization. Doctor Burton is writing a first-person account of his adventures which will be published in the next *Michigan Medicine.*

More patients than usual have been filing into Doctor **E. James Gordon's** office in Escanaba, but not because they are sick. They've just dropped by to tell him "thanks" and "good luck." Doctor Gordon, a farmer and math teacher before deciding on surgery for a career, is retiring after many years of service in this Upper Peninsula community.

* * * * * * *

Physicians wishing to learn more about what Michigan is doing to provide quality medical care in prisons and jails will be interested in the article which appeared in the June 12 issue of *AMA News*. The publication called heavily upon **Jay Harness, MD**, of Ann Arbor, and **Dennis Jurczak, MD**, of Jackson, in preparing this feature.

* * * * * * *

Paul Pomeroy, MD, Pontiac, and **Judith E. Tintinalli, MD**, Detroit, have co-authored an article on "Hypertensive Encephalopathy" published in the July issue of *JACEP*, journal of the American College of Emergency Physicians.

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Ronald L. Krome, MD, Detroit, has assumed the presidency of the University Association of Emergency Medicine. Doctor Krome is director of emergency services at Detroit General Hospital and associate professor of surgery at WSU.

* * * * * * *

J. Robert Willson, MD, of Ann Arbor, has been named president-elect of the American Gynecological Society, and will be assuming the presidency of the organization in May 1979. Doctor Willson is professor and chairman of obstetrics and gynecology at the University of Michigan.

* * * * * * *

Denis F. Cash, MD, Bloomfield Hills, has been named medical director of General Motors Parts Division and **Robert S. Rhoades, MD**, is the new associate medical director at the Hydra-matic Division of GM in Ypsilanti.

Henry Ford Hospital has announced two new appointments. **James A. Ausman, MD**, has been named chairman-elect of the Department of Neurosurgery-Neurology, and **Joseph L. Ponka, MD**, has been selected medical director of the HFH West Bloomfield Center.

* * * * * * *

"Principles of Weight Loss" is the title of the feature appearing in the July *Michigan Health Educator* written by **Joseph Arends, MD**, of Detroit. Doctor Arends' article advises "how to trim down and stay that way."

* * * * * * *

Cited for his dedicated service as a psychiatrist in Northern Michigan is **John G. Lipski, MD**, of Harbor Springs. Doctor Lipski is recipient of a Certificate of Appreciation, presented by the Northern Mental Health Centers, Inc.

* * * * * * *

Moses Cooperstock, MD, of Marquette, is the recipient of the President's Award for Distinguished Service, presented by Northern Michigan University. NMU President John S. Jamrich cited Doctor Cooperstock for his pioneering efforts in the development of pediatric care in the Upper Peninsula and for helping to establish Marquette as a pediatric-orthopedic center in the U.P.

* * * * * * *

The Michigan Lung Association has awarded Christmas Seal Fellowships to **Walter J. Willoughby, Jr., MD**, Ann Arbor, and **Robert E. Klimek, MD**, East Lansing. Doctor Willoughby will receive lung disease specialty training at the U-M Medical Center Pulmonary Division under John G. Weg, MD, physician-in-charge, and Doctor Klimek's specialty training will be under Samuel M. McMahon, MD, Lansing, director of Medical Chest Services at Ingham Medical Hospital and director of MSU's medical chest program.

* * * * * * *

Doctor Sweeny, AMA Council chairman, likes 'being where important action is'

By C. R. Shelton
Grosse Pointe

Donald N. Sweeny, Jr., MD, surgeon and senior partner at Riverside Clinic, Detroit, chairs one of the most influential councils of the American Medical Association.

He is chairman of the AMA Council on Medical Service, which is charged with maintaining an overview of socioeconomic factors which affect the delivery of health care.

The Council of Medical Service is composed of nine members, most of whom also are House of Delegates members. Doctor Sweeny was elected to the Council in 1972 and has been chairman for the past two years. Council members are elected by the association's House of Delegates and now are eligible to serve three terms of office. Each term is for a three year period.

The full Council meets five to six times per year, usually for two to four days, and members frequently are called upon to appear before various government agencies and to speak at meetings of other health care societies or associations.

Health care consultants

"One of the many important projects of the Council is the review of material from the board of trustees and House of Delegates on socioeconomic issues," says Doctor Sweeny. "The Council makes recommendations on those issues, as well as any others that we think important.

"We are consultants for the board on the delivery of health care, and are responsible for implementing the AMA's policy on that broad subject.

"The Council writes about 15 or 20 reports each year for the House of Delegates where action is taken and changes, or innovations, are initiated.

"We research many subjects that affect the nation's delivery of health care and write 'white papers' on areas that we feel need action. We recently heard testimony, on measures which the insurance industry proposed in the area of cost containment, and prepared a 'white paper' on that subject.

"We closely monitor PSRO efforts — actually the Council is the AMA liaison between HEW and the AMA's efforts for Professional Service Review Organizations. The entire Council is involved in work on national health insurance.

"While the Council cannot, of itself, make changes in AMA policy, we do suggest innovations as we see need for them, and may implement certain House of Delegates' approved changes under the direction of the board."

Some personal background

Doctor Sweeny long has been active in medical, church, and civic organizations. Just a few of the impressive medical posts he holds, or has held, include: past president, Detroit Academy of Surgery and Detroit Surgical Society; trustee, American Association of Medical Clinics (1958-1972); judicial commissioner, MSMS (1965-1972); chairman, MSMS Legal Affairs Committee; Executive Committee, Greater Detroit Area Hospital Council, Inc.; member, Medical Practice Board; secretary and trustee, Wayne County Medical Society.

Doctor Sweeny says he first became seriously interested in the work that led to his rise to AMA Council chairman back in 1952 when he was appointed to the Wayne County Medical Society Ethics Committee.

Asked why such a busy physician devotes the time and effort necessary to successfully chair one of the AMA Councils, Doctor Sweeny responded he believes the work of the AMA is vital to the people of this country and to the medical profession.

"Of course, if I didn't have such a benevolent group of physicians working with me at the Clinic and if my family were not so understanding, I would not be able to continue my Council work.

Doctor Sweeny

"I anticipate and enjoy the personal contact with the people who are working out the future of American medicine. I work closely with top echelon government officials and experts in other associations, and I like the give-and-take basis on which we can wrestle with a problem area, sometimes square-off verbally with one another, but usually come up with something that is good for all concerned.

AMA aggressive organization

"I believe strongly in the American system of medicine and in the American Medical Association. In the past five years I have seen the AMA change from a conservative, slow-moving group which mainly reacted to most things and seemed to be always trying to catch up, to an aggressive, imaginative, innovative organization which causes things to happen.

"The AMA has become a body that is listened to. We are not radical, but we are progressive. We do not always oppose things, but make recommendations that are constructive. For instance, I believe we have helped to make Medicare better for the people.

"These days, the government comes to the AMA for suggestions on proposed legislation. In the past, we would have been the last group that bureaucrats would have consulted.

"Positions on the Councils are vied for. Though we receive no pay for our work, we do get the satisfaction of knowing that as members of the Councils we have the most important positions in the AMA other than the Board of Trustees.

"You might say that I do it because I like being where the important action is . . . and helping to make the action happen."

Meet Doctor Griffin, MSMS president-elect

By Judith Marr
Managing Editor

"The involvement of all the physicians in Michigan in medical society activities would be the best thing that could possibly happen to us," says MSMS President-elect Ernest P. Griffin, Jr., MD, Flint.

Doctor Griffin believes the future of the medical society must revolve around increasing membership to include all Michigan MDs.

"It's the only way I can see us being able to hold our position against federal and state intrusions into the practice of medicine," he says. "It's important for us to increase our membership so we can actually speak for the whole profession."

Doctor Griffin believes the major issue facing medicine today is to see that the profession remains in the private sector.

Another major issue, he says, is making sure that "our people are doing the best job possible," through continuing medical education.

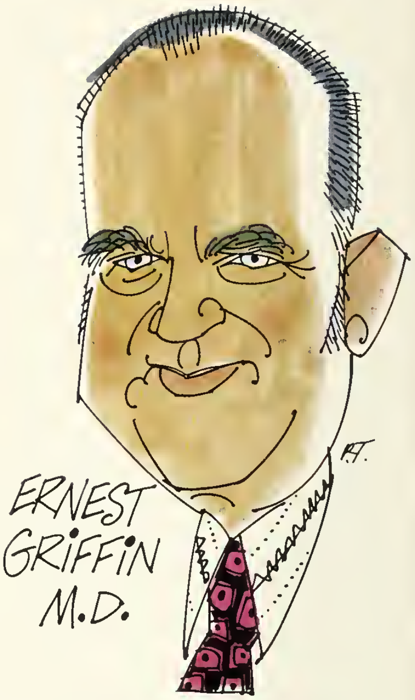
"Ernie," as he's affectionately known by his colleagues, was elected MSMS president-elect in May. He had served as Council chairman since May, 1975, and before that was chairman of the important Council Finance Committee. He was instrumental in the formation of the Michigan Physicians Mutual Liability Company and now serves as a member of the board.

Though an Arkansas native, Doctor Griffin has been in Michigan since 1938, when he began an internship at Hurley Hospital. He met and married Marie Sexsmith of Flint at that time. They went to New York where Doctor Griffin took advanced training. He then served in the Army for five years, and returned for a visit to Flint. He took over a practice temporarily and has been in Michigan since.

"I spend all my time in medicine," says the hard-working radiologist. However, he does fly a Cessna 210, mostly for recreation and on vacations, and he enjoys golf.

Mrs. Griffin has been president of the local YWCA and serves now as an advisor to Y committees. She also has served as president of the Genesee County Medical Society Auxiliary.

The Griffins have three children: Walter, an attorney with the Flint firm of Cline and Cline, which does much medical malpractice defense work; Patricia, who holds a PhD in counseling and guidance and is on the faculty and Orange Coast College, Costa Mesa, Calif.; and Richard, who has just graduated from the Tulane Law School and is studying for the Michigan Bar Exam.



A graduate of the University of Arkansas, Doctor Griffin is a radiologist. He is affiliated with St. Joseph Hospital, Flint. He has been a councilor with the Radiological Society of North America and is a fellow of the American College of Radiology. He is past president of the Genesee County Medical Society and the Michigan Radiological Society. He also served on the board of directors of the Michigan Medical Service.

WCMS contributing anatomical model to Science Center

The Wayne County Medical Society is making a significant contribution to the new Detroit Science Center, a modern "hands-on" facility promoting scientific learning and culture.

The WCMS is raising funds to donate a Transparent Anatomical Manikin (TAM) to the center as its contribution. The $71,000 needed for the TAM is being raised by the WCMS Auxiliary. The Else Kolhede Foundation has contributed $9,000 and the Auxiliary itself has agreed to contribute $10,000.

The first fund-raising event will be the Nov. 18 Society-Auxiliary Dinner Dance. The Science Center has agreed to offer one-year associate memberships to any medical society member who donates $25, and will place names of contributors of $100 or more on a plaque to be displayed in the TAM auditorium.

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MSMS working closely with new health data group

MSMS is actively participating with the new Michigan Health Data Corporation. The MHDC was formed in the spring to serve as a continuing central data collection agency supporting projects concerned with health care and delivery in Michigan.

Since its formation, the MHDC has been endorsed by the MSMS Council. Daniel J. Fall, MD, Ann Arbor, is serving on the board of directors as the MSMS representative.

The chief reason for MSMS participation, says Doctor Fall, is that the MHDC "has the potential for collecting a lot of very sensitive data and we need to be sure the data are properly used.

"We need to be sure the proper confidentiality is maintained," he says. "Our principle function is to serve as a monitor of the data collection and use."

There are 15 organizations from government, academic and private worlds with representatives on the MHDC board, which evaluates proposed research projects and administers the money granted for the projects it finds acceptable. The board also acts as the agent to contract with organizations interested in providing information and computer facilities in support of projects.

The board supervises the data collection to insure quality, and is responsible for dissemination of the results of the projects.

The current project is to collect data on hospital utilization and resource management and analyze it, using a set of proposed formulas. These formulas compare features of hospital administration such as patient population, length of stay and intensity of service. The results are to be used to assist hospital administrators in the formulation of policy. The data will compare one region of the state to another.

All organizations involved will have equal access to the data gathered.

Executive director is Larry Brown.

Those organizations which are involved are:

Blue Cross/Blue Shield of Michigan
Commission on Professional and Hospital Activities
Greater Detroit Area Hospital Council
Health Insurance Association of America
Michigan Association of Health Systems Agencies
Michigan Association of Osteopathic Physicians and Surgeons
Michigan Department of Management and Budget, Office of Health and Medical Affairs
Michigan Department of Public Health
Michigan Department of Social Services, Bureau of Medical Assistance
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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M. A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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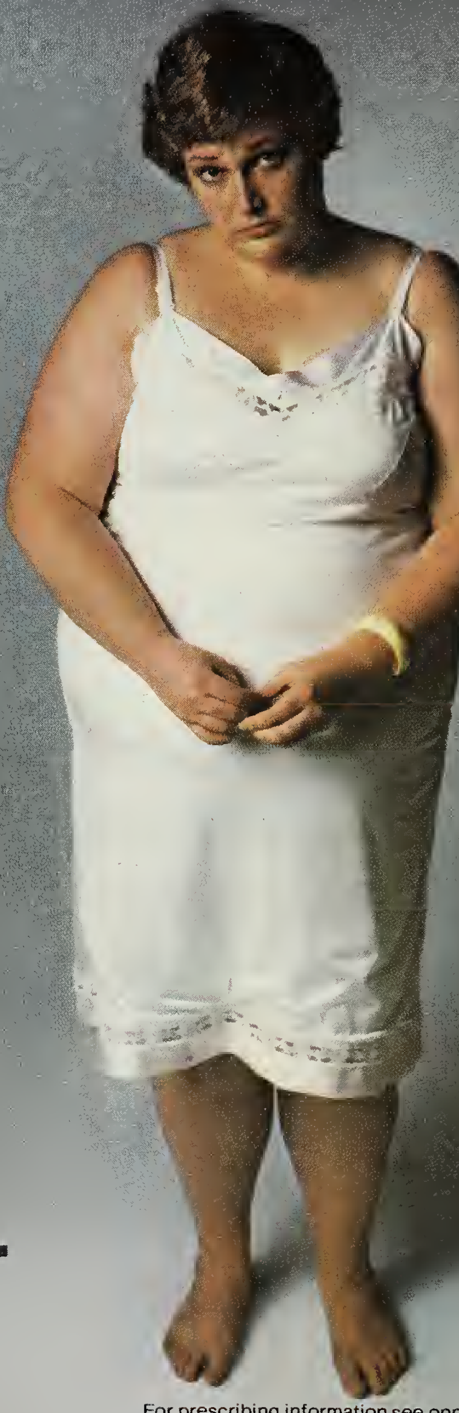

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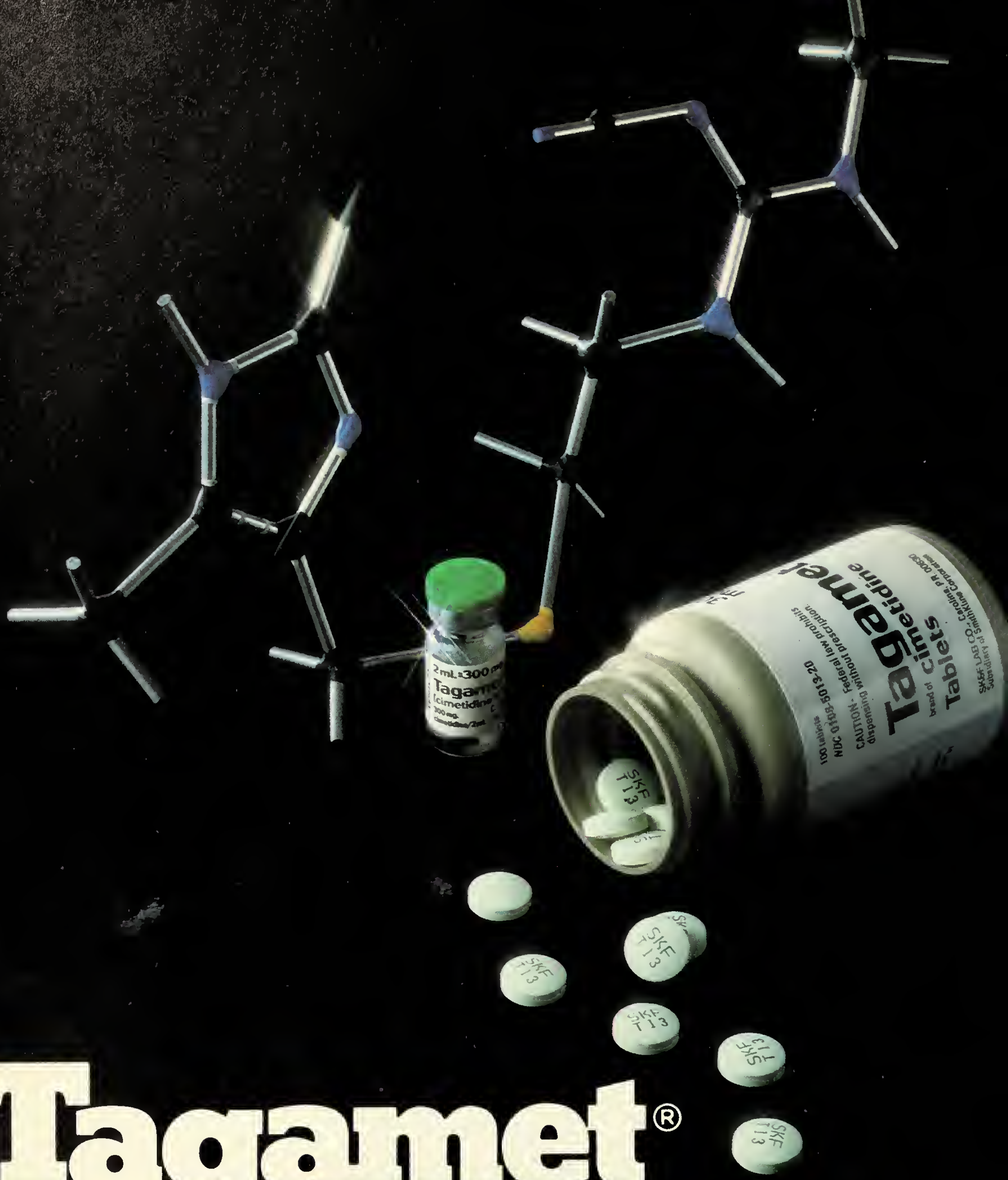
For prescribing information see opposite page.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List is continued on next page.

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Age 45-49 — $202.50
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Age 55-59 — $450.00

This $25,000 coverage is with the current, well-established MSMS group life plan underwritten by The Mutual Benefit Life Insurance Company of Newark, N.J. All plan provisions apply to the open enrollment amount.

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Rebuttal: PAs not technicians, but educated professionals

Doctor Birch

By William G. Birch, Sr., MD, LLD
Largo, Florida

In *Michigan Medicine*, July 1978, Archie M. Bedell, MD, expressed apprehension over the physician's assistant role in providing professional care to patients. To quote his article, "Medical schools stress differential diagnosis and treatment of patients, and emphasize that a physican be trained as a thinker, a detective, a scientist, a problem solver, a diagnostician and not a technician.

My reaction to this was one of discomfort, because he unscientifically expanded his basic lack of awareness into some generally undocumented conclusions.

First of all, he assumed quality care is automatically, if not somehow divinely, provided by all who possess a doctoral degree. He furthermore assumed, in the same type of sweeping generalization, that all medically educated professionals short of this sacrosanct level are incapable of delivering quality health care services unless closely monitored or directed. It is easy to develop "professional myopia" associated with this type of limited thinking.

Issue not who, but what

It should come as no surprise to some that few physicians go through a clinical day without using technology and assistance in both diagnostics and therapeutics beyond their ability or desire to develop independently or understand comprehensively. Who of us steps to the laboratory to run and read a blood sugar, X-ray a GI series or do a cross-match for transfusion? So who is really independent from what? It would appear that the issue here is not "who controls whom" but "what is the final outcome of health care activity."

It is my fervent ongoing hope that those who fear encroachment by these new medically educated professionals get out, get to know some of them and thereby put to rest many of their unfounded fears.

PA program requires experience, study

Physician's assistants are not technicians but educated professionals. At Western Michigan University, they are required to have at least two years of liberal arts, as well as a year working in the medical field (i.e., RN, LPN, medical or radiological technician) prior to their entrance into the program.

Study includes didactic and clinical courses in all of the major fields as well as supervised exposure to patients in these areas. The student graduates from WMU after 24 months with a certificate and the degree of Bachelor of Science in Medicine. The course, in other words, includes the essentials needed for primary care, excluding some of the exotic nonessentials as well as repetitives. It is a very hard course, but even so, most are honor graduates of the University. (See appended curriculum.)

Doctor Bedell feels that the MD should be selfish of his prerogative. I would suggest that he level his concerns at those who work in the field with inadequate substandard education. Doctors do not need to protect themselves from their helpers.

The Physician's Assistant is capable of doing his or her work cooperatively under the direction of the doctor, who is the employer. The doctor should be able to delegate activity as with others. So far there have been no physicians hiring a graduate PA who have had a malpractice suit — they're doing much better than an equal number of physicians working without PAs!

If some day I become ill, I may be cared for by a PA. The care will be more than adequate and if needed, the physician will be near at hand, his practice less cluttered by routines so that he can spend more of his time and energy working on my problem.

Selfish restriction of diagnosis, examination and treatment is an emotional, illogical approach to care of patients.

Physicians' assistants are not likely to "get in over their heads." Honestly, can we say the same of ourselves? They have "inside" help if needed. We don't.

PAs proud of being extenders

Regretfully, it has been my observation that many of those physicians who object to the use of PAs or desire over-restriction of their usefulness below the level of their education, are ignorant of what these people really are, or insecure in their own role. They could gain much by employment of Physicians' Assistants who know their role and are proud of being extenders (not substitutes) for the care busy physicians provide.

After all, which is more important? Care of our patients or of ourselves? Isn't that which is good for them good for us?

In Michigan it took several years of study and development by many physicians and educators before the first student was admitted to our school — probably longer than development of any medical school curriculum in the United States.

Just remember that these PAs are not trained technicians, but educated professionals.

Doctor Birch is former clinical director of the Western Michigan University Physician's Assistant Program.

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Medical Practice Board's job has to be done; it's best done by physicians, says President Wilson

By Charles Downs
Special to Michigan Medicine

This article is the first in a series of three designed to better inform Michigan physicians on the organization, purposes and philosophies of the Michigan Medical Practice Board. Interviews with Board President John R. Wilson, MD, Grand Rapids, have provided the bulk of material for the articles.

Being a member of the Michigan Medical Practice Board (MPB) is hardly a sensible job for a pragmatic physician.

You are required to attend meetings in Lansing at least once a month. And for that trouble you receive the princely sum of $35 per day plus expenses.

You have to read voluminous transcripts of public hearings; this and other homework requires about 20 hours per week for which you receive no pay at all.

Board hats black?

But the toughest part is that even after you do your work well and conscientiously, most of your colleagues, it seems, find fault with what you do or what they think you do. You soon get the feeling that other doctors see a black hat on your head.

Intellectually, you can conceive reasons for such an attitude on the part of your peers, but still it is hard to accept.

So says John R. Wilson, MD, a Grand Rapids pediatrician who serves as president of the MPB. He speaks from experience — seven years on the board. He has one more year to go in the second four-year term to which the governor has appointed him. After that he plans to call it quits, not because it has not been rewarding (as well as frustrating) but simply because he feels he has done enough and that others should take part in the process.

The MPB is established by law as the body which implements and enforces other state laws dealing with the licensing and regulation of medical doctors in the state. The board is staffed by the Department of Licensing and Regulation, which provides similar staff services to other boards dealing with osteopathic physicians, dentists, optometrists, barbers, beauticians, and others.

"Physicians ought to know much more about the MPB than most of them do," says Doctor Wilson. If they did, he believes, they would see it not as a stumbling block but as a splendid opportunity to upgrade the practice of medicine.

"We often are accused of being Lansing bureaucrats," he says. "But of the 13 members of the Board, 10 are active practicing physicians. The other three represent consumers."

Why then is the MPB resented and criticized by physicians?

Part of the problem is that when a doctor has dealings with the Board — aside from routine licensing — it is bad news; a doctor has been accused of doing something unlawful and he is resentful.

"The Board is an authoritarian institution and people resent authority," says Doctor Wilson. "Also, we are punitive and that too is resented because we live in a society that stresses rehabilitation."

Another part of the problem, according to the Grand Rapids pediatrician, is the basic mental set — the self confidence — of most physicians.

"All of us," he notes, "have developed an attitude that says we know what we are doing. And to a large degree, we cannot function effectively without this attitude because we have to believe in ourselves. Consequently, we tend to resent any kind of interference."

"But we also have to be accountable and recognize that we can be and probably will be wrong on occasion."

Board not known

However, the main reason physicians criticize the Board, says the MPB president, is that most physicians simply do not know very much about it.

"In particular, what they do not seem to realize is that the Board does not make up the law, but only enforces it," he stresses.

"We work under a state statute and we must live within its guidelines."

For the most part this statute is quite reasonable, particularly in that it essentially permits physicians to police themselves, a privilege that will likely be revoked if physicians fail in the task, Doctor Wilson contends.

"This is a job that has to be done and it is best that it be done by physicians. If we turn it over to others, we are in trouble."

(Next month: the work of the Board and the rights of physicians to due process.)

MEET THE MPB

Members of the Michigan Medical Practice Board are:

John R. Wilson, MD, president, Grand Rapids pediatrician. His term expires in 1979.

Donald H. Kuiper, MD, vice president, Lansing gastroenterologist. His term expires in 1979.

Margaret J. Thoms, secretary, Birmingham housewife. Her term expires this year.

F. Ann Pillote, MD, Marquette pediatrician. Her term expires in 1979.

Carol E. Person, MD, Oak Park psychiatrist. Her term expires in 1979.

James C. Breneman, MD, Galesburg allergist. His term expires in 1979.

Arthur J. Majewski, Detroit lawyer. His term expires in 1979.

James W. Burdick, Southfield lawyer. His term expires in 1979.

Henry A. Kallet, MD, Jackson pathologist. His term expires in 1981.

John F. Fennessey, MD, Detroit pathologist. His term expires in 1981.

Alma Rose George, MD, Detroit surgeon. Her term expires in 1979.

Addison E. Prince, MD, Detroit obstetrician and gynecologist. His term expires in 1981.

James L. Fenton, MD, Bay City radiologist. His term expires in 1981.

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Letters

"... long and mutually advantageous participation ..."

Enclosed please find our completed application for exhibit space at the 1978 Annual Scientific Meeting of the Michigan State Medical Society to be held at the Detroit Plaza Hotel, Renaissance Center, Detroit, Nov. 7-9. Also enclosed is our check for $400 to cover the cost of the exhibit space in full.

We appreciate your plans to recognize long-time exhibitors at your meetings. Although our Company probably attended earlier meetings, our record of participation begins with the year 1920. According to our information, the meeting was held in Kalamazoo that year on May 25-27, and the cost of exhibit space was $15. Glancing further down the list, I see that the first time the society held its meeting in the fall was in 1923. The Hotel Pantlind in Grand Rapids was the location on Sept. 11-13 of that year, according to our records. I then see a notation for the years of 1926 and 1927 that the Council at a January meeting voted not to have exhibits at the annual meetings in those two years. Except for that, it appears that we have exhibited every year since beginning to keep records in 1920.

It has been a long and, we hope, mutually advantageous participation, and we look forward to a most successful meeting this year, also.

Robert J. Miller, Vice President
Consumer Affairs and Promotion
Medical Protective Company
Fort Wayne

"... a privilege I shall cherish ... rest of my days."

Events of these past few months have given me cause to reflect on my lot in life. On balance, I would conclude that I have been treated very kindly by the fates.

One of the most precious honors I have ever received was your Presidential Citation on behalf of the Michigan State Medical Society. This is a privilege I shall cherish for the rest of my days.

Since the announcement, I have been honored by radio station WJR and was the recipient of a heartwarming editorial on the pages of the Lansing State Journal.

For a state medical society to bestow its blessing upon a state bureaucrat is mind-boggling. Credit must be given to my 15 years as a practicing physician. This has made me sensitive to the enormous contribution of the practicing physician to the delivery of health care in this country.

Again my eternal gratitude.

Maurice S. Reizen, MD, Director
Michigan Department of Public Health

"... good cheer to all ..."

I was most pleased to learn of the recent honors bestowed on the journal, *Michigan Medicine*. Please express my appreciation to your editorial staff.

Changing, stirring times in the field of medicine as expressed in your journal and "Capsule Bulletin" and your publications help to keep me informed.

Life is full and happy in this "land of pleasant living" on the eastern shore of Chesapeake Bay. I am still working 18 hours a week as a consultant at the Eastern Shore Hospital Center in Cambridge, MD. Sailing and many other activities fill my time to overflowing with no place for boredom. It hardly seems possible that I have been away from Michigan for 4½ years — for time passes so quickly in this restful rural area.

Alice joins me in "good cheer" to all.

Robert J. Mason, MD
Oxford, MD

(Doctor Mason was MSMS president in 1969-70.)

"... I challenge the Blues ..."

At the June 28th meeting of the Council of Specialty Societies held at MSMS headquarters in E. Lansing, two representatives from the Blues were present. In a question and answer period it was proposed that the Blues would be prudent to bring to MSMS for its consideration any new, major changes in the medical package which will be worked out between the autos and the UAW next year. It would then be possible for an exchange of ideas to take place regarding feasibility and cost-impact *before* the final details are settled upon.

"Cost-containment" is a great phrase and has been used as a whip for many purposes. The Blues and physicians are committed to this concept, and we must *work together* to achieve it. One concrete way would be to avoid adding costly, frivolous items to an already abundant contract. Perhaps Blue Cross-Blue Shield could do this more conveniently with strong MSMS backing.

I challenge the Blues to accept this proposal and include physicians in the early stages of planning the medical package!

G. E. Moore, MD, Secretary-Treasurer
Michigan Society of General Surgeons

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Category I courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Oct. 18, **Diabetes for the Clinician. Location:** Kalamazoo Center, Kalamazoo. **Sponsor:** American Diabetes Association, and The Upjohn Company. **Co-sponsor:** Southwestern Michigan Area Health Education Center. **For:** Family physicians and internists. **Cost:** $25 physicians, $10 house officers. **Contact:** C. L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 252 East Lovell Room 364, Kalamazoo, 49006, (616) 383-6360. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 18, **The School-Age Parent. Location:** Mott Children's Health Center. **Sponsor:** Mott Children's Health Center and Hurley Medical Center. **For:** Pediatricians. **Cost:** $12. **Contact:** Richard D. Garlick, Director, CME, Hurley Medical Center, 6th Ave. and Patrick St., Flint 48502. **Approved for:** 5 hours of Category I Credit.

Date: Oct. 21, **Regional Infectious Disease Symposium — V.D. Location:** Hurley Medical Center, Merliss Brown Auditorium, Sixth Avenue & Begole Street, Flint, 48502. **Sponsor:** Hurley Medical Center. **For:** All specialties. **Cost:** $30. **Contact:** Richard D. Garlick, Director of CME, Hurley Medical Center. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 21, **Diagnosis in Psychiatry. Location:** Zuckerman Auditorium, Sinai Hospital of Detroit. **Sponsor:** Kingswood Hospital, Mt. Carmel Mercy Hospital, Providence Hospital, Sinai Hospital of Detroit. **Co-Sponsor:** Michigan Psychiatric Society. **Cost:** $25 course fee; $15 registration fee. **Contact:** Mr. Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 25, **Brief Psychotherapy. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, psychotherapists. **Cost:** $50/$30. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 25, **Internal Medicine workshop on gastrointestinal malignancies. Location:** Kresge Auditorium, Harper Hospital, Detroit. **Sponsor:** Harper Hospital Department of Medicine. **For:** Internists. **Contact:** Ms. Catherine Canzonetta, Department of Medicine, Harper Hospital, 313/494-8210. **Approved for:** 3 hours of Category I credit.

Date: Oct. 26, **Nutritional Support of the Hospitalized Patient. Location:** Troy Hilton. **Sponsor:** Jason Bodzin, MD, Director, Surgical Education, Mt. Carmel. **Cost:** $25. **Contact:** Jason Bodzin, MD, 313/864-5440, Ext. 656. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 27-28, **Otorhinolaryngology. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otolaryngologists. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 28, **Nutritional Support of the Hospitalized Patient. Location:** Troy Hilton Hotel. **Sponsor:** Nutritional Support Team, Mt. Carmel Mercy Hospital and Medical Center. **Cost:** $40. **Contact:** Pat Dunkel, Mt. Carmel Mercy Hospital and Medical Center, Detroit. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 31, **Continuing Pathology. Location:** Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, U of M Medical School. **For — Specialty:** Pathologists. **Cost:** $25. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 1, **Sleep Disorders. Location:** Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **For:** Primary care physicians. **Cost:** $25. **Contact:** Medical Education Office, 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 2, **Second Annual Michigan Family Practice Research Day. Location:** MSU University Club, East Lansing. **Sponsor:** Department of Family Practice, MSU College of Human Medicine, and Michigan Academy of Family Physicians. **Contact:** Doug McKeag, MD, Chairman, Research Day Planning Committee, MSU Department of Family Practice, East Lansing, 48824, 517/353-00850. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 4, **Current Occupational Health Concerns. Location:** Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **For:** Primary care physicians. **Cost:** $60. **Contact:** Medical Education Office, 313/876-1464. **Approved for:** 7½ hours of Catetory I Credit.

Date: Nov. 6-8, **Minimal Breast Cancer. Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists, surgeons, hematologists. **Cost:** $160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Michigan physicians may write MSMS, 120 W. Saginaw St., East Lansing, 48823 for meetings of later dates.

Date: November 6-10, **Counseling Older Adults and their Families; Principles of Milieu Therapy: Working with the Elderly in Treatment Settings. Location:** University of Michigan. **Sponsor:** Institute of Gerontology, University of Michigan. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109. **Approved for:** 3.5 hours of Category I Credit.

Date: Nov. 7-9, **MSMS Annual Scientific Meeting. Location:** Detroit Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** MSMS. **For:** All specialties. **Cost:** $4/credit hour for members; $8/credit hour for non-members. **Contact:** Herbert Auer, MSMS headquarters, 517/337-1351. **Approved for:** 20 hours of Category I Credit.

Date: Nov. 8, **Fifth Annual Grand Valley Seminar on Pulmonary Disease. Location:** Hospitality Inn, Lansing. **Sponsor:** Michigan Lung Association. **Contact:** Andrew W. Kovacs, Program Director, Michigan Lung Association, 403 Seymour Ave., Lansing, 48914, 517/484-4541. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 10-11, **26th Annual Trauma Day. Location:** Harper Hospital, Webber Wing, 3990 John R., Detroit. **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons and WSU Department of Surgery. **Cost:** $60. **Contact:** Joseph L. Posch, MD, 1408 Cales Bldg., Detroit 48226, 313/962-0727. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 13-14, **Oncology-Hematology. Location:** Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Primary care physicians. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Nov. 15-16, **Mammography for Radiologic Technologists. Location:** Towsley Center for CME, Ann Arobr. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the U of M Medical School. **For:** Radiologic Technologists. **Cost:** $80. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 14 hours of Category I Credit.

Date: Nov. 16, **The High Risk Neonate: A Symposium on Birth Defects. Location:** Mercy College, Detroit. **Sponsor:** Metropolitan Detroit March of Dimes Health Professional Advisory Committee, Wayne County Medical Society and Wayne State University College of Nursing/College of Life Long Learning. **Cost:** $30. **Contact:** Joan Leavy, 313/864-6000. **Approved for:** 8 hours of Category I Credit.

CATEGORY I/*continued*

Date: Nov. 17-18, Otorhinolaryngology Conference. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, U of M Medical School. **For:** Otolaryngologists. **Cost:** $120. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 12 hours of Category I Credit.

Special programs planned this fall

The Department of Nuclear Medicine at William Beaumont Hospital is offering a four-week comprehensive review of the current status and update in the latest developments in Nuclear Medicine.

The program will feature lectures, film interpretation sessions, and workshop participation in radioimmunoassay, radiopharmacy and computer applications. It is intended to be of most benefit to those physicians either engaged in the field on a part-time basis or anticipating full or part-time involvement.

Course participation will be arranged at a mutually agreeable time.

For further information, contact J. E. Freitas, MD, program coordinator, William Beaumont Hospital, 3601 W. 13 Mile Road, Royal Oak, 48072.

* * *

A scientific program honoring Elizabeth C. Crosby, PhD, ScD, on the occasion of her 90th birthday will be held Saturday, Oct. 28 at the Dow Auditorium, Towsley Center, Ann Arbor. All students of Doctor Crosby are cordially invited.

Among those giving presentations will be Muriel Ross, MS, PhD, associate professor of anatomy, U-M Medical School; Clement Fox, PhD, emeritus professor of anatomy, WSU School of Medicine; Norman Schnitzlein, PhD, professor of anatomy, University of South Florida Medical School; and Robert Rand, MD, PhD, professor of neurosurgery, University of California Medical School, Los Angeles.

For further information, contact Richard C. Schneider, MD, professor of surgery and head of the Section of Neurosurgery, University of Michigan Medical Center, Ann Arbor 48109.

Date: Nov. 17-18, Medical-Surgical Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians, surgeons. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Nov. 28-30, Diagnosis and Treatment of Arrhythmias. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the U of M Medical School. **For:** Internists. **Cost:** $180. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 21 hours of Category I Credit.

Date: Dec. 5, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Dec. 9, December Seminar. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit or James W. Landers, MD, Department of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 18-20, Rheumatology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Rheumatologists, internists, family physicians. **Cost:** $150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: Jan. 28-Feb. 2, Fourth Annual Seminar, "Emergencies in Medicine." Location: Boyne Highlands, Harbor Springs. **Sponsor:** Michigan Committee on Trauma, Michigan Society of Critical Care Medicine. **Cost:** $40. **Contact:** Robert F. Wilson, MD, or Theresa Sokol, WSU, Dept. of Surgery, School of Medicine, 540 East Canfield Ave., Detroit, 48201. **Approved for:** 23 hours of Category I Credit.

Date: Feb. 4-9, Family Practice Update. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $200. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: Feb. 15, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 19-23, Emergency Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians, internists, emergency physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 35 hours of Category I Credit.

Date: Feb. 27-28, Psychophysiologic Illness. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, primary care physicians. **Cost:** $100. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Feb. 28-March 1, Michigan Conference on Maternal and Perinatal Health. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Herb Auer, MSMS, 517/337-1351. **Approved for:** 14 hours of Category I Credit.

Date: March 6-9, Hematology Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Hematologists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: March 14-16, Advances in Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians. **Cost:** $160. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: April 12, Conference on Medical Aspects of Sports. Location: Towsley Center, Ann Arbor. **Sponsor:** MSMS. **Contact:** Herb Auer, MSMS, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 16-20, Family Practice Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: April 24, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: May 10-11, Ophthalmology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12 hours of Category I Credit.

Date: May 14-18, Head and Neck Oncology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otorhinolaryngologists, surgeons. **Cost:** $500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: May 21-25, Advances in Internal Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Internists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: June 7-8, Blood Banking. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $90. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

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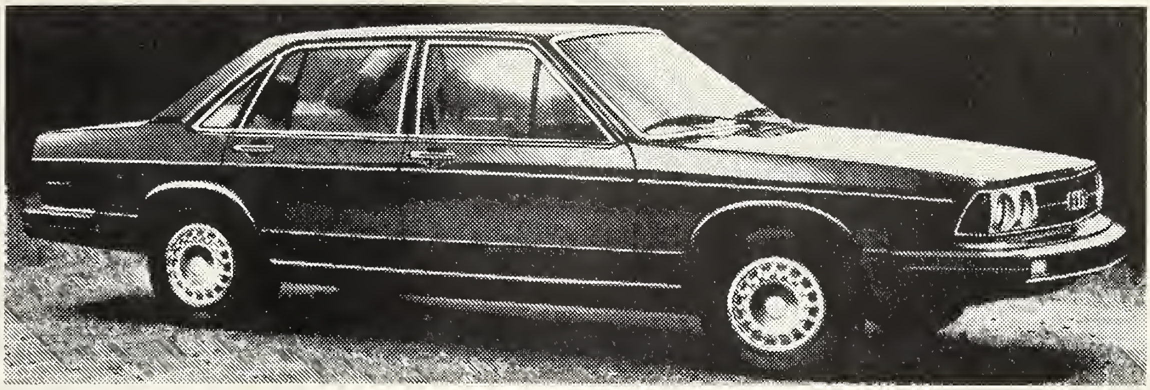

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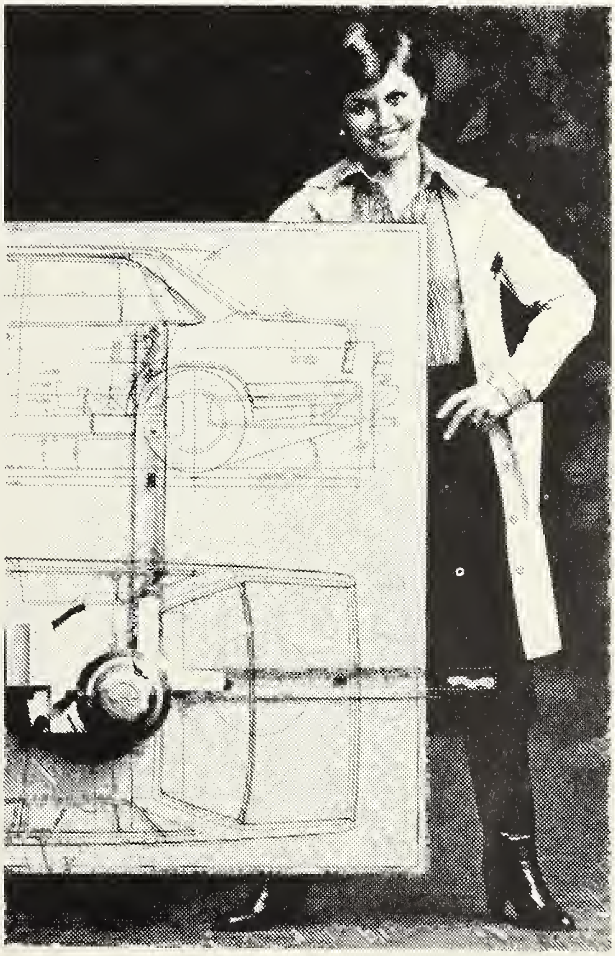


Isn't it usually the other way round? Finkenzeller: Well, I suppose it's a bit unusual for a woman to be a structural engineer. But I am and it happens that my husband is not, although, he's very good at his job. I've been designing automotive components for 15 years.

How will women feel about the Audi 5000? Finkenzeller: Good. They'll like its layout. It is probably the most intelligent 15½ feet of engineering on the road today. My colleagues developed a 5-cylinder gasoline engine that has plenty of power, yet doesn't take up unnecessary space inside, so the Audi 5000 seats five people very comfortably. Actually, it's a big car. In fact, I believe, in your country, it's the largest German luxury car for the money, less than $9,000.*

Will men like the Audi 5000? Finkenzeller: Men? Of course. I think they will love its power and handling. The Audi 5000 may be an elegantly conservative car but it's not sedate. With front-wheel drive, it takes corners beautifully, especially for such a big, luxurious car. People are always surprised to find out how responsive this car is. That amuses us.

Are you always this sensible? Finkenzeller: Sensible? If you mean logical and precise, I'd say yes, when it comes to doing my work. In my profession, I have to be precise. However, if what you really want to know is whether I'm ever emotional or even romantic, perhaps you should ask my husband about that.

*Suggested 1978 retail price $8,780, P.O.E., transp., local taxes, and dealer delivery charges, additional. Come test-drive the Audi 5000 at your local Porsche+Audi dealer.

See your nearby Audi dealer.

New trend sees Michigan hospitals combining in various multi-unit arrangements

By Ellen Louhi
Special to Michigan Medicine

Michigan hospitals are accelerating the trend to enter into multi-hospital arrangements, reports the Michigan Hospital Association.

An MHA task force on multi-hospital arrangements finds that shared services are being engaged in by more and more hospitals for purposes of economy.

The increasing complexity of hospital management, increasing governmental regulations and third party payer requirements are making it difficult for smaller hospitals to develop the depth of management teams required in today's social environment, says MHA President Patric E. Ludwig.

Such activities as Public Law 92-641, Blue Cross initiatives, Medicare-Medicaid regulations, medical education and training requirements, certificates of need processes, rate review, the legislative thrust of states and the federal government and new technology indicate that new approaches must be tried.

"If hospitals fail to respond, they will lose their ability to provide the quality of service demanded," Mr. Ludwig says.

Shared services

Of all the multi-hospital arrangements that exist, shared services are the most varied. By participating in shared services, a situation exists where certain agreed-upon management, administrative or clinical services can be shared among institutions with agreements or contracts having built-in termination factors.

The MHA task force studied data from arrangements available as of January, 1978, on multi-hospital arrangements. It grouped these arrangements under several categories.

The category of Administrative Shared Services includes hospitals which either received or provided services. They also are listed in one of four IRS categories, most engaging in nonprofit hospital contract services with one or more administrative or clinical services being provided.

For instance, Saginaw Community Hospital with 350 beds receives Biomed/Clinical Engineering services and laundry/linen.

Henry Ford, with 1,051 beds, receives services in a larger number of categories: audiovisual, credit and collections, group insurance, public relations, purchasing materials management and quality assurance/utility review.

On the other hand, it *provides* services in such areas as consultants, education/training, medical education and personnel management/collective bargaining.

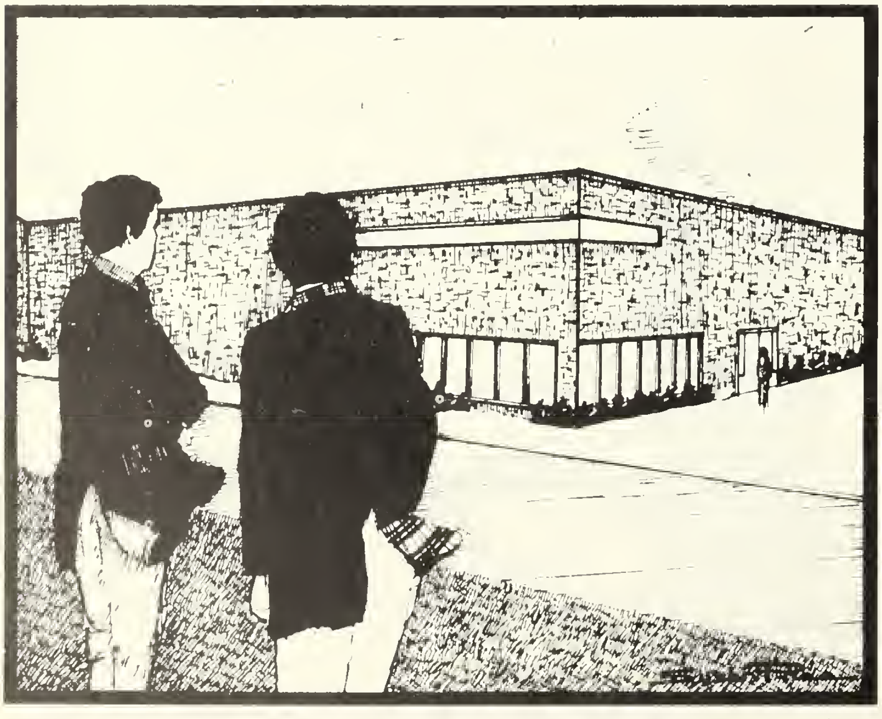
In another Task Force category, Clinical Shared Services (Exclusive), a variety of provided services are listed. For example, Port Huron Hospital with 249 beds reports five instances of providing services: alcohol rehabilitation/chemical dependency, emergency services/trauma; obstetrics/pediatrics, nurseries — normal/special care, organ transplant/physical medicine rehabilitation. The latter includes occupational therapy, physical therapy, recreational therapy and speech pathology.

In two categories Port Huron receives services — cancer diagnosis and treatment, including radiotherapy and chemotherapy, and enterostomal therapy and lab test chemistry.

Port Huron contrasts with Clare Osteopathic, Inc. which has 66 beds, and receives only one area of services, coronary care remote and continuous monitoring.

Again Port Huron appears under the designation of Concentrated Clin-

(Continued on page 578)



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ical Shared Services. Those services are in ophthalmology and pediatrics.

Henry Ford, among the largest hospitals listed, appears in the category of Basic Clinical Shared Services in three areas: electrocardiology, electroencephalography and health education.

Hospital consortia

In addition to the various types of Clinical Shared Services there are 12 hospital consortia involving 43 hospitals.

What is the consortia? It is a mechanism developed to coordinate and share services, programs and staff among participating hospitals on a voluntary basis. It does not involve ownership or control of these organizations by any of the parties involved.

For instance, there may be agreements to centralize in a designated hospital or hospitals specific services, such as cobalt therapy, CAT scanning, renal dialysis, obstetrics, pediatrics and cardiac surgery.

The hospitals also may agree to joint planning and educational services to refrain from developing any new service until it is agreed upon by other member institutions in the consortium. Consortia frequently have a central executive who serves as the coordinator of various services and planning.

In the Southwestern Michigan area a consortia for Health Education includes Bronson Methodist and Borgess hospitals, Michigan State University and the University of Michigan. Its mission: medical education.

In Washtenaw, Hillsdale and Lenawee counties, eight hospitals have coordinated resources. They are Emma Bixby, Herrick Memorial, Hillsdale Community Health Center, Morenci Area, Thorn, Addison Community, Henry Ford and Saline Community. They share resources, develop and expand resources and the capabilities of members hospitals.

Eight hospitals are managed by four management corporations. Hospital Affiliates International manages Menominee County Lloyd, Iron County General and Portage View. Saginaw General manages Harbor Beach Community, Deckerville Community and Hills and Dales General. Northern Michigan Hospitals manages Russell Memorial and Munson Medical Center oversees Kalkaska Memorial Health Center.

All these are full contract management agreements without ownership. In this arrangement, the administrator who is appointed by the external contracting agency reports both to the board of directors of the managed hospital and to the chief executive officer of the contracting agency.

Hospital corporations

Another multi-hospital arrangement is the corporation. Thirty-seven hospitals have been merged into 18 hospital corporations in Michigan. These are located in Bay City, Cheboygan, Detroit, Garden City, Grand Rapids, Iron Mountain, Jackson, Lansing, Marquette, Monroe, Petoskey, Royal Oak and St. Joseph.

There are also hospital satellites where the main body initiates sub-hospital systems as opposed to merging. The smaller facility provides for inpatient and outpatient services in the neighboring community with referrals to the major hospital as dictated by the circumstances. In the South, a number of Baptist hospitals are organized in this fashion.

In Michigan, hospital satellites completed or in progress early this year are located in Cheboygan, Dearborn, Detroit, Newberry and Southfield. Six hospitals operate 14 satellites.

As an example, Cheboygan satellites include Cheboygan-Presque Isle Health Care, Inc., Indian River Clinic, Mackinac Straits Clinics, Cheboygan Clinic and two other clinics in Cheboygan.

Other multi-hospital devices include multi-hospital corporations, with units of a single corporation. Thirty units are a part of eight multi-hospital corporations in Detroit, Farmington, Mt. Clemens, Royal Oak and Wayne.

A variety of arrangements exist for multi-hospital formations to meet emerging needs for services as well as for compliance with governmental regulations.

What does this trend mean for affiliated physicians? It offers a possibility for better patient care because of the opportunity for peer review, says Ludwig. It also provides an opportunity to transfer the patient to an appropriate setting that will render better care for a particular type of treatment.

The MHA task force's report, an inventory of specific hospital involvement in these types of multi-hospital arrangements, is available as a reference source for hospitals seeking more information about entering into such arrangements.

Films available on special children

Three films dealing with handicapped children and their families — one a low-birth-weight baby, one handicapped as a child and another with learning disabilities — are available for use by physicians. The films describe the special feelings and problems of the children and families involved and were produced for the Ingham (County) Intermediate Parent Advisory Committee. Further information is available from Nels Bullock, Project FIND coordinator, Ingham Intermediate School District, 2630 W. Howell Road, Mason, 48854.

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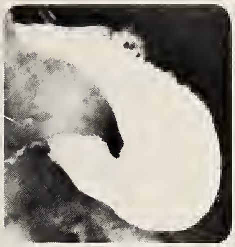
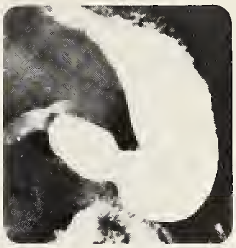
. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary
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Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with autonomic neuropathy, hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension, hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis) Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur ADVERSE REACTIONS. Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation; constipation, bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs.
Usual Dosage Bentyl 10 mg capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg. *Adults.* 1 tablet three or four times daily Bentyl Injection: *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
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MSU expands in UP

Calumet and St. Ignace have been selected as sites for two new health and medical education centers of the Upper Peninsula Medical Education Program, administered by Michigan State University's College of Human Medicine and the UP Health Education Corporation.

The new health centers, made possible by a grant from the Kellogg Foundation, will be used for patient care, educating medical students to become MDs and for postgraduate residency training of physicians to become family practitioners.

Opening dates for the centers depend on availability of facilities, and appointment of physician instructors and other health professionals in the two cities.

The UP Medical Education Program's first health care center is located in Escanaba. It served as headquarters for the first 10 graduates who completed MD training in the innovative program, and received their doctor of medicine degrees this past spring from MSU.

Calendar for AMA, MSMS Auxiliary and Medical Assistants

Oct. 18-19 — Auxiliary District Meeting, Marshall, contact: Helen Schulte, MSMS headquarters.

Nov. 1 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 7-9 — MSMS Annual Scientific Meeting, Detroit Plaza Hotel, contact: Herb Auer, MSMS headquarters.

Dec. 2-6 — AMA House of Delegates Interim Meeting, Chicago.

Dec. 7 — AMA Winter Scientific Meeting, Las Vegas.

Dec. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

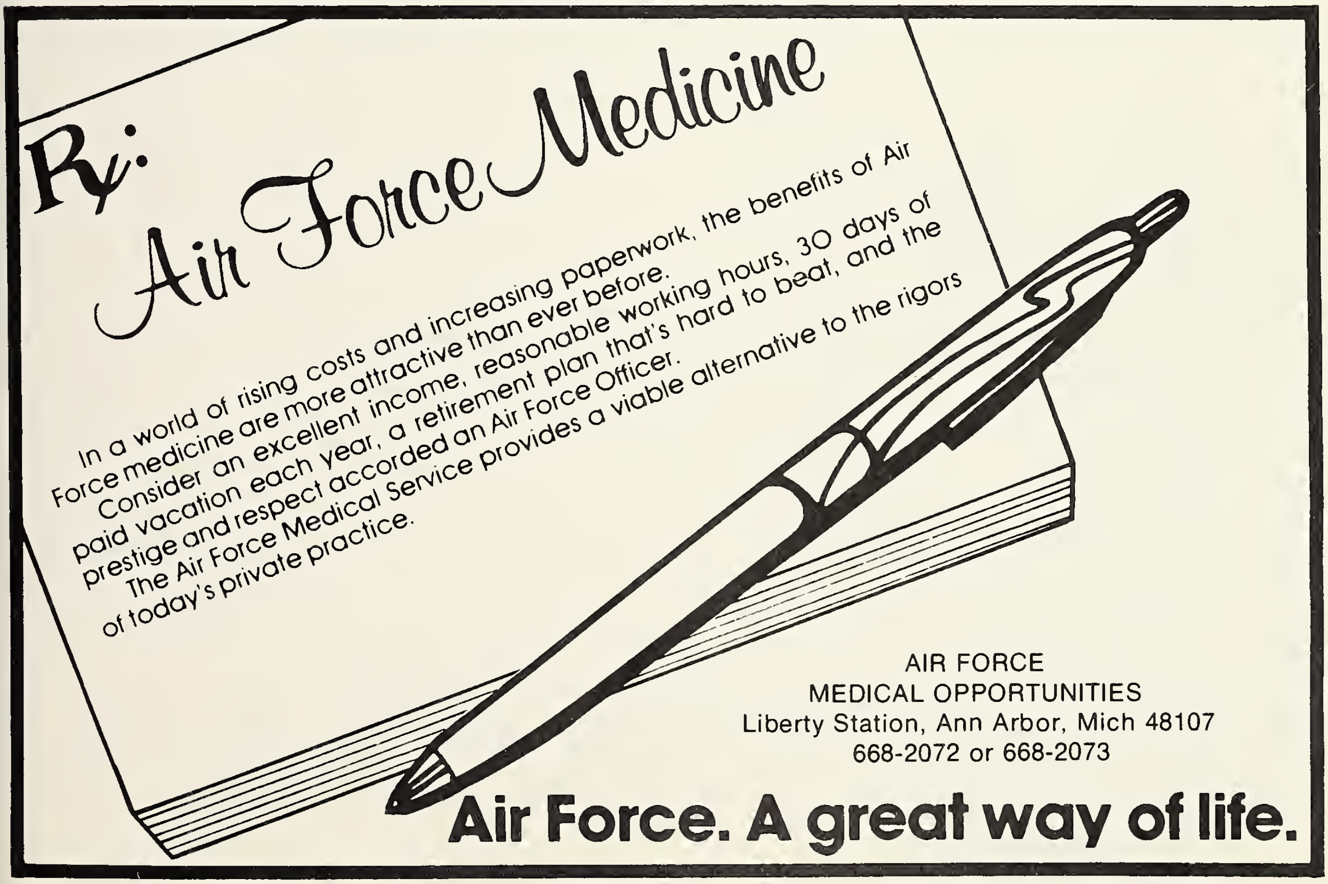
Feb. 3-4 — Medical Assistants Mid-Winter Seminar, Jackson, contact: Helen Schulte, MSMS headquarters.

Feb. 28-March 1 — MSMS conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Herb Auer, MSMS headquarters.

March 4 — Medical Assistants Board Meeting, MSMS headquarters, contact: Helen Schulte, MSMS headquarters.

April 12 — MSMS Conference on Medical Aspects of Organized Athletics, Towsley Center, Ann Arbor, contact: Herb Auer, MSMS headquarters.

April 26-29 — Medical Assistants State Convention, Lansing, contact: Helen Schulte, MSMS headquarters.



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Deaths

Robert M. Bradley, MD
Flint

Robert M. Bradley, MD, Flint, died Aug. 11 at the age of 73. A graduate of the University of Michigan Medical School, Doctor Bradley was associate chief of staff in obstetrics and gynecology at St. Joseph Hospital. He was a member of the Flint Academy of Surgery and the American College of Obstetricians and Gynecologists.

Saul Brown, MD
Birmingham

Saul Brown, MD, Birmingham, died Aug. 23 at age 51. Doctor Brown, senior assistant attending pathologist at Sinai Hospital, Detroit, was a graduate of the Wayne State University School of Medicine. He was also an associate professor there. His memberships included the College of American Pathologists and the Michigan Society of Pathologists.

Charles W. Cooley, MD
Jackson

Charles W. Cooley, MD, Jackson, died Aug. 13 at the age of 58. Doctor Cooley was chief radiologist at Foote Hospital West. A graduate of the University of Michigan Medical School, his society memberships included the American Roentgen Ray Society and the Radiological Society of North America. He served as treasurer of the Jackson County Medical Society.

John M. Dorsey, MD
Detroit

John M. Dorsey, MD, age 77, of Detroit, died Aug. 6. Retired head of the Wayne State University School of Medicine's department of psychiatry and the only man in the school's history to be named a university professor, Doctor Dorsey received his medical degree from the University of Iowa.

Doctor Dorsey studied with Sigmund Freud while doing graduate work at the University of Vienna and wrote a book about Freud. He was on the Wayne State faculty as a psychiatrist and head of the mental hygiene services, and later became professor and chairman of psychiatry.

Doctor Dorsey had served in various capacities with the Children's Center, Children's Fund of Michigan, Wayne County Juvenile Court, McGregor Center, Veteran's Administration Hospital in Allen Park and Harper Hospital. He also was affiliated with Children's Hospital, Detroit General Hospital, the Mayor's Committee for the Rehabilitation of Narcotic Addicts, the Mayor's Youth Commission and Mental Health Committee, the Mental Health Committee of the Wayne County Medical Society, the Michigan Advisory Committee on Multiple Sclerosis, the State Board of Alcoholism and the Governor's Committee on Sex Deviates.

Campbell Harvey, MD
Mexico

Campbell Harvey, MD, formerly of Oakland County, died Aug. 15 at the age of 89. A pediatrician, Doctor Harvey graduated from the University of Michigan Medical School and was affiliated with St. Joseph's Mercy and Pontiac General hospitals, Pontiac. He was a member of the University of Michigan Pediatric and Contagious Disease Society; the American Academy of Pediatrics, Michigan chapter, and the Detroit Pediatric Society.

Samuel D. Jacobson, MD
West Bloomfield

Samuel D. Jacobson, MD, West Bloomfield, died Aug. 4 at 64 years of age. The Wayne County General Hospital medical director was a graduate of the Wayne State University School of Medicine. He was on the faculty of the University of Michigan and Wayne State University medical schools, and was a member of the American College of Physicians.

Francis P. O'Linn, MD
Grosse Pointe Park

Francis P. O'Linn, MD, 63, of Grosse Pointe Park, died July 18. He was a member of the American College of Obstetrics and Gynecology.

William F. Veling, MD
Detroit

William F. Veling, MD, 60, of Detroit, died July 14. The inventor of the Veling Heart Monitoring System, Doctor Veling received his medical degree from the Wayne State University School of Medicine. He served as a captain in the U.S. Army Medical Corps during WWII and was on the staffs of Grace and Highland Park General hospitals.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android®/5 Buccal mg./10 Oral mg./25 Oral mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

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2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Classified

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication. Classified advertisers using box numbers prefer not to disclose their identity. Your inquiries in writing will be forwarded to box number advertisers. The right is reserved to reject or modify all classified advertising copy in conformity with *Michigan Medicine* style.

Positions open

FAMILY PHYSICIAN WANTED, residency or experience, willing to do OB, family practice background preferred. Located in rural health center in beautiful Northern Michigan. Economically stable community within the heart of four-season recreation. Good schools. Apply: Administrator, East Jordan Family Health Center, P.O. Box 718, East Jordan, MI 49727. (Salary negotiable.)

OCCUPATIONAL PHYSICIAN — For large multi-specialty group in beautiful Milwaukee, WI area — new facility of long established clinic. Office space and all equipment supplied by group. Pre-employment exams, diagnostic evaluations, on-the-job injuries for more than 300 Milwaukee area plants. Challenging position with great future for advancement. Excellent salary — many fine benefits including liberal profit sharing plan. Replies held in strictest confidence. Write Box 12, ℅ MSMS.

PEDIATRICIAN: Board eligible or certified wanted as associate in private practice in Mid Michigan location, population 60,000. Two year contract: salary first year $35,000 and second $40,000 with additional malpractice insurance, hospitalization insurance, medical association fees. Two weeks vacation. Immediate opening. Call 517/893-4085 after 6:00 p.m.

WANTED — Physician specializing in internal medicine and orthopedic surgery and must have a degree in those specialties and at least four years experience as a practitioner in those specialties. Wages: $20,000. Contact Henry Ford Hospital, 2799 West Grand Blvd., Detroit, MI.

MARQUETTE, MICHIGAN — Expanding referral center has positions available both immediately and in the future for an allergist and a part-time director of medical education. Also needed are additional physicians in the following specialties: obstetrics, gynecology, hematology, oncology, pulmonary disease, primary and consultative internal medicine, and dermatology. Fully equipped hospital with: advanced lab facilities, CT Scanner, active cardiovascular surgery, active participation in the training of MSU medical students, and a family practice residency beginning in 1979. Current staff of 79 solo and small group private practitioners; 87 percent board certified; average age of active staff is 42. University town on unspoiled Lake Superior with all recreational activities. Send curriculum vitae or call: John D. Wojcik, MD, Recruitment Committee, Marquette General Hospital, 420 W. Magnetic Street, Marquette, MI 49855. 906/228-9440, extension 434.

OPHTHALMOLOGIST — Board certified/eligible Ophthalmologist sought to associate in an established practice. Major regional medical center consisting of 43 multi-specialty physicians in Northwest Ohio. Top salary and excellent fringe benefit program along with all corporate benefits. Please forward curriculum vitae, salary requirements to MSMS, 120 W. Saginaw, Box 11, East Lansing, MI 48823.

TROY — PSYCHIATRIST WANTED for a private Out-Pt. Clinic. Bd. eligible or Bd. certified. Multidisciplinary, dynamic and very active practice. Salary dependent upon experience and negotiable. Excellent working conditions and location. Please contact Y. M. Alkar, MD, Medical Director, 2151 Livernois, Troy, MI 48084 or call 313/362-4144.

FIVE-ROOM NEWLY REFURBISHED clinic needs occupancy. Want a full-time, part-time or semi-retired physician. Located in upper peninsula where the air is pure, the water unpolluted and nature is your neighbor. If interested please correspond with Blair Vickerman, Chairman, Medical Committee, Box 27, Grand Marais, MI 49839.

RESIDENT OR PART-TIME PHYSICIAN for Saturday at Family Clinic. Call or write — Trail Clinics, P.C., Cindy Papuga, Clinic Secretary, 313/861-4400, 18254 Livernois, Detroit, MI 48221.

FAMILY PRACTITIONERS, INTERNISTS, and/or OB-GYNs needed in growing, prosperous Dutch community to join a Board Certified family physician in existing practice, or solo available. Excellent economy with medical education, recreational lakes, and ski resorts within 20 mile radius. Will help solo practice to start out. Guarantee net income of $40,000 for first year partner. Call Grand Rapids, MI, 616/531-9803 between 9 and 11 p.m.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park, there are openings for physicians board qualified as internists, family physicians or psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently between forty-five and fifty-five thousand per year, plus 23% fringe benefits, including life, accident, long term disability, dental, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. Liability insurance not necessary. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7830.

OPHTHALMOLOGIST — needed now to associate with three others in beautiful central Upper Peninsula of Michigan. Lakes, hunting, fishing and clean air. General or just medical ophthalmologist. Contact MSMS, Box 16, 120 W. Saginaw, East Lansing, MI 48823.

MIDLAND — Staff psychiatrists (2) for 305 bed acute care hospital including 16 bed psychiatric unit, with half time in affiliated outpatient mental health center. Both adjacent and newly remodeled. Family practice residency program. Affiliation with Michigan State University Department of Psychiatry. 100,000 catchment area. Ideal for family life. Excellent school system. Cultural opportunities. Year round recreation area. Salary comparable to area psychiatrist — negotiable. Liberal fringe benefits. Contact: Harvey Chapin, MD, Recruitment Task Force, Midland Hospital Center, 4005 Orchard Drive, Midland, Michigan 48640, Ph. 517/631-2320.

Positions wanted

POSITION WANTED/CLINIC ADMINISTRATOR — Energetic man with health care management experience would like to asssociate himself with a professional group. Call 313/477-8084.

Miscellaneous

ONE OR BOTH OF TWO CHOICE LOTS at Presque Isle, Michigan. Overlooking harbor. Retirement or recreational land. Full clubhouse and sports facilities. Details on request. Reasonable. 313/548-4777.

OFFICE SPACE — suitable for professional. South Westnedge and Milham area, Portage, Michigan. Modern six-year-old building, first floor, 1100 square feet, ample parking and full basement included. Three exam rooms, two bathrooms and laboratory. Phone: 616/327-4459.

SHARE OFFICE SPACE — three-five days per week. Good for psychiatrist, general or specialized surgeon. Office fully equipped. Excellent location. Area between Pontiac and Rochester. Call Monday thru Friday. 10:00 a.m. to 5:00 p.m. 313/852-4100.

FANTASTIC NORTHLAND EXECUTIVE RETREAT! Six plus acres of fabulously landscaped land, three-bedroom stone veneer cottage with huge fieldstone fireplace, plus large gazebo with fieldstone barbeque. Paved road but secluded privacy. Near Rose City. Plus almost 1000 feet of Houghton Creek bubbles past your door as it winds through this beautiful setting. $60,000, 8% contract available. Call Loraine, Great Northern Real Estate. 517/685-2661 or 345-0831.

USED MEDICAL EQUIPMENT FOR SALE — A. Description of equipment: One (1) Philips 600 G 6" I.I. 2-way system including connecting cable, mirror viewer, 6E rack cabinet, 3E covers, and test phantom. Date purchased: October 1975. Highest offer accepted. B. Description of equipment: spectrotherm 2,000, including image storage subsystem, camera, clamp on mirror, and movable stand (115 Volt-60HZ). Date purchased: August 1974. Highest offer accepted. Call 616/673-8424, Ext. 245.

AU SABLE RIVER/NEAR GRAYLING. 1,230-foot frontage with three modern cabins completely furnished. Large cabin sleeps eight. Beautifully wooded property with mature trees. Facilities are ideal for three or four family ownership or as an organizational retreat. Will consider dividing. Land contract terms. Brochure on request. EACO Realty, Box 21203, Lansing, MI 48909. 517/686-5660.

FOR SALE — 320 Acres — Excellent deer and pat hunting. Located S.W. of Alpena on four county lines — N.E. corner of Oscoda Co. bordered by Alpena, Montmorency and Alcona Cos. The Turtle Lake Club is our neighbor to the north and west. Three buildings — Main sleeping cabin — fireplace and gas propane heat, 1½ car garage. Week days call Bill or Jack, 313/644-0100.

GROUP PRACTICE NEEDED — all new medical center in prime location of Brighton. 2000 square feet office unit, includes four exam rooms or more, private office and entrance, laboratory, excellent parking, ideal to accomodate one or two doctors. Immediate occupancy. Call Davis Professional Bldg., 313/229-2752.

Kellogg funds MDPH to establish cost-effective outpatient data system

A new grant of $343,436 by the Kellogg Foundation to the Michigan Department of Public Health is designed to establish a cost-effective ambulatory care health information system in seven Michigan family practice residency training centers.

The purpose of the two-year project is to demonstrate the use of an economical computer-based system to display information about patients and their problems, for better management of office medical practice, and for self-evaluation by doctors of the quality of care given, cost containment, and the impact of care on patients.

The funds will be granted to the Michigan State University Department of Community Health Science, which will direct the project.

Robert Oakes, MD, Battle Creek, will serve as medical director.

The project will be guided by an advisory group consisting of the directors of participating family practice residencies in seven Michigan communities. The advisory panel includes Archie Bedell, MD, Grosse Pointe; Harold Crow, MD, Lansing; Leo Bingley, MD and Robert Weber, MD, Flint; Charles Morrill, MD, Grand Rapids; Robert Toteff, MD, Saginaw, and Everal M. Wakeman, MD, Dearborn.

MSMS Scientific Meeting offers new opportunities for practicing physicians to meet educational needs

The MSMS Annual Scientific Meeting with its extensive offering of 58 courses will go a long way to meeting many of the needs of community physicians.

The community physician has ready for him or her a wide choice of courses that will provide new information and new suggestions for daily practice.

Most practicing physicians have their own agenda of learning that nurtures special interests or meets their own felt needs. Hundreds come every year to the MSMS Scientific Meeting, not for credit alone, but because courses will provide answers for them.

Local physicians, often ridiculed and poorly understood by medical students and house staffs, already have a wealth of information in their personal data banks and the experience to use it quite effectively.

Yet the excellent courses arranged for Nov. 7-8-9 at the Detroit Plaza by the highly-regarded course directors offer new opportunities for the practicing doctor. In just a three-hour, half-day course, the physician can hear distinguished Michigan medical educators or visitors from other states and countries. The physician can ask questions about specific cases back home. She or he can confer with colleagues about their experiences in their many communities.

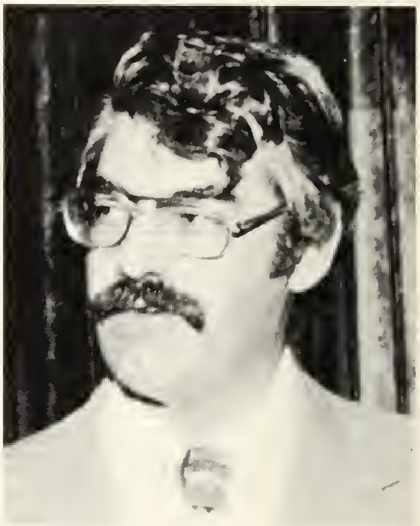
I have encouraged every course director and instructor coming to the Scientific Meeting to prepare at least a brief outline and bibliography that will allow the physician to read and study further back home.

Let me urge all physicians active on their local hospital staffs or in their county medical societies to consider adapting or repeating one of the 58 courses back in their home communities during the coming year.

Can some of the needs that you personally perceive be met by inviting the faculty from one of the courses to travel to your town? MSMS can assist with arrangements. Courses approved by the MSMS Committee for CME Programming at the Annual Scientific Meeting can provide Category I credit when taken into the local communities.

I salute the many physicians who will come from smaller communities. These doctors, where patient-physician ratios may be unfavorable — will again extend themselves to keep up-to-date with advancements in the practice of medicine.

MSMS President Louis E. Heideman, MD, has invited Doctor Hammerstrom to serve as guest columnist this month.



Carl F. Hammerstrom, MD
Chairman, MSMS Committee on CME Programming

In closing, I want to commend Robert F. Wilson, MD, Detroit, who is serving his third year as general chairman for this big MSMS meeting. I thank also the 58 course directors, the hundreds of instructors, the many cooperating medical school departments and specialty societies, and the fine MSMS staff for making the 1978 Scientific Meeting possible.

I am looking forward to meeting many of you there. I sincerely welcome your evaluations and your suggestions for the 1979 meeting.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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Her next attack of cystitis may require

the Bactrim™ 3-system counterattack

ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Entero bacteriaceae* in the bowel without the emergence of resi tant organisms. Thus, Bactrim reduces the risk of introit colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine Medigram

VOL. 77, NO. 30 OCTOBER 19, 1978

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NOV 8 1978

Last chance to advance register for MSMS Scientific Meeting Nov. 7-9

It's Annual Scientific Meeting Time!

Members who have not registered for some of the 58 CME Category I courses may still do so by using the attached registration form. But, please do it today.

Members still trying to clear their office calendars may come directly to the Detroit Plaza Nov. 7-8-9 and register then. Those physicians must come one hour before the starting times for the courses. It is possible that some of the courses might be filled because their enrollment limits are dictated by the size of the rooms.

Advanced registrations have been good, with many of the doctors also reserving rooms at the spacious Detroit Plaza. Some special events are planned for the spouses on Nov. 7 and 8.

Interest is especially high among family physicians because 44 of the courses have been approved by the American Academy of Family Physicians for "prescribed credit."

"Every Michigan physician can find a course that will provide practical information to help him or her practice better medicine, or to be a better informed physician," stresses Louis R. Zako, MD, chairman of the MSMS Council. "This meeting is one of the biggest state society events in the nation and is expertly planned by the Program Chairman Robert F. Wilson, MD, MSMS Committee for CME Programming, and by the able staff," Doctor Zako adds.

As physicians register for courses, MSMS is sending special instructions about available parking facilities. Physicians registered for afternoon courses are urged to get to the Plaza by 11 a.m., to enjoy luncheon in the MSMS Exhibition Hall and to be ready for the 1:30 afternoon courses.

Your last chance . . . to register in advance for the 1978 MSMS Annual Scientific Meeting is offered by this *Medigram.* A complete registration form for the Nov. 7-8-9 event at the Detroit Plaza Hotel appears on page 5.

Special enrollment . . . opportunity for MSMS group life insurance plans is described on page 3 of this *Medigram.* A tear-off form allows you to sign up now, with no proof of insurability required.

APSULES

SMS PRESIDENT Louis E.
eideman, MD, will respond
o many of the proposals of
he Preliminary State Health
lan at hearings scheduled in
ovember by the Statewide
ealth Coordinating Council.
hey will take place: Nov.8
-10 P.M., Hospitality Inn,
rand Rapids; Nov. 9, 6-8P.M.
MU Conference Center, Mar-
uette; Nov. 13, 1-4 P.M.,
ity-County Building, Detroit.
ny interested physician may
ttend and speak at the meetings.
SMS reactions to the prelim-
nary SHP will be detailed in the
ovember and December issues of
he Michigan Medicine.

BALLOTS FOR THE NEXT MSMS Judicial Commission election will go in the mail Nov. 1 to physicians in the affected districts. Elections will be held during November for commissioners from Districts 1, 4 and 6. Deadline for return of ballots is Dec. 1.

* * *

INTERESTED MSMS MEMBERS may sign up now for the Michigan Doctors Study Club 1979 Study-Ski Seminars. The week long ski-trip seminars are planned Feb. 9-16 at Snowmass, March 2-9 at Vail and March 23-30 at Snowmass, all in Colorado. Complete information may be obtained from Richard Campau at MSMS headquarters.

* * *

THE MSMS COMMITTEE on CME Accreditation has approved Heritage Hospital of Taylor, the Michigan Ophthalmological Society, the West Shore Consortium for CME, Inc. and Portage View Hospital, Hancock for offering Category I CME programs. That brings to 54 the total of Michigan hospitals approved for Category I. An additional 22 specialty societies, medical schools, and other health organizations are accredited in Michigan, either by MSMS or the AMA.

'Housecall' to air again at 7:30 p.m. Nov. 7 on Channel 56

The next live medical TV call-in show, "Housecall," is scheduled at 7:30 p.m. Nov. 7 on Channel 56, Detroit. The program, jointly sponsored by MSMS and the Wayne, Oakland and Macomb county medical societies, inaugurated its season Oct. 3. Physicians who answered the public's questions about medical care during that program were C. Jackson France, MD, Detroit general surgeon; Robert Murray, MD, Detroit family physician; and Charles Vincent, MD, Detroit obstetrician/gynecologist. "Housecall," now in its fifth season on the public TV station, drew 180 questions by telephone in its first segment this year.

Ophthalmologists contract with MS for administrative services

The Michigan Ophthalmological Society is the newest of several organizations now contracting with MSMS for administrative services. Thomas Cleary, former MOS executive, will continue with the organization as legislative specialist. Other organizations which currently have all or part of their administrative work carried out by the MSMS Office of Special Services (Helen Schulte, manager) are: Michigan Society of Anesthesiologists, Michigan Association for Medical Education, Michigan Society of General Surgeons, Michigan Society of Respirator Therapists, Michigan Psychiatric Society, MSMS Auxiliary and American Association of Medical Assis ants, State of Michigan.

Medicaid needs MD consultants

Medical consultants are needed to assist the Medicaid program in conducting physician profile reviews in the areas of obstetrics, general practice and cardiology. The MSMS Medicaid Liaison Committe urges physicians to consider a short-term consultan role as part of a collective effort to curb abuse o misuse of the Medicaid program. For more information, contact Sherry Wellman at MSMS headquarters.

PLEASE SEND ENTIRE PAGE WITH CHECK

1978 Michigan State Medical Society Annual Scientific Meeting Registration Form for Category I CME Courses

* Courses Approved for Prescribed Credit by the American Academy of Family Physicians

TUESDAY MORNING, NOV. 7

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Basic Cardiac Life Support
*_____ Common Pitfalls in the Management of Malignancies
*_____ It's Now Easy to Recognize & Manage Chronic Obstructive Pulmonary Disease
*_____ Management of Diabetes Mellitus — Problems in Acute and Chronic Care
*_____ Newer Developments in the Evaluation and Treatment of the Hypertensive Patient
_____ Sex and the Heart Patient
*_____ What's New and Practical in Peripheral Vascular Surgery

TUESDAY AFTERNOON, NOV. 7

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alcohol and Medical Practice
*_____ Assessment and Management of the Patient with Acute and Chronic Renal Failure
*_____ Care in the September Years
_____ Current Trends in Coronary Artery Bypass Graft Surgery
*_____ Sexuality: New Recognition Or Another Perspective of an Old Subject
*_____ What's New and Practical in Office Endocrinology
*_____ What's New in Anti-Arthritics, Beta-Blockers, Bronchodilators, Vasodilators — With Special Attention to New Agents & Drug Interactions

On Tuesday evening, Wayne County Medical Society will present its Annual Beaumont Lecture at a dinner program. Write to WCMS, 1010 Antietam, Detroit 48207 for details about program and registration.

The courses will provide 3 hours of Category I credit toward the state relicensure requirements and the AMA Physicians Recognition Award.

Please check the courses you wish to attend. In each case please indicate a second choice should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, luncheon tickets, etc., must be picked up at the MSMS Registration Desk upon arrival at the Detroit Plaza.

Physicians must make their own hotel reservations prior to 10/16/78 direct with the Detroit Plaza Hotel, Renaissance Center, Detroit, MI 48243. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Scientific Meeting.

WEDNESDAY MORNING, NOV. 8

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*FILLED Advanced Cardiac Life Support (A 16-hour course to run all day Nov. 8 and 9. (See tuition below)
*_____ Common Errors in Pediatric Management
*_____ Diagnosis & Treatment of Common Esophageal Disorders
*_____ Diagnosis & Treatment of Patients with Hematologic Disorders
*_____ Diagnosis & Treatment of Pneumonia and Legionnaires' Disease
*_____ Evaluation of the Dizzy Patient for the Family Physician
_____ Lead Poisoning — An Update
*_____ New Concepts in Peptic Ulcer Disease / New Approaches to Obstructive Jaundice
_____ Newer Developments in Diagnosis and Treatment of Neurological Problems
*_____ Office Dermatology for the Non-Dermatologist
*_____ Office Gynecology for Non-Gynecologists
*_____ What's New in Surgery

WEDNESDAY AFTERNOON, NOV. 8

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Congestive Heart Failure — New Concepts in Evaluation and Therapy
*_____ Cost Awareness and Medical Care
*_____ Current Concepts and Management of Common Pediatric Surgical Problems
_____ Current Management of Hemorrhoids, Anal Fissures and Anal Fistulas
_____ Cutaneous Manifestations of Systemic Disease
*_____ Dealing with Women Patients
*_____ Diagnosis and Treatment of Allergy and Bronchial Asthma in Children
*_____ Diagnosis and Treatment of Common Rheumatic Disorders
_____ Identification and Management of the High-Risk Obstetrical Patient
*_____ Male Sexual Problems: Impotency, Infertility
*_____ Nuclear Medicine — Review of Current Applications and New Developments
*_____ Physicians and Their Families
*_____ Poisonings in the Emergency Department

THURSDAY MORNING, NOV. 9

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Diagnosis and Treatment of Common Athletic Injuries
*_____ Diuretic Therapy: Applications and Complications
*_____ Exercise in Medicine: Controversies, Indications, Proper Prescribing, and Precautions
*_____ Frequent Problems in ECG Interpretation
_____ Immunology and Inflammatory Bowel Disease
_____ Interpreting the Biochemical Profile
_____ Nosocomial Infections: Recognition and Management
*_____ Role of Hyperalimentation in Common Medical and Surgical Disorders
_____ Scientific Medical Writing
_____ Transplantation: Current Status and Future Prospects

THURSDAY AFTERNOON, NOV. 9

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Antibiotic Therapy — New Advances
*_____ Chronic, Non-Alcoholic Liver Disease
_____ Common Problems in Thoracic Surgery
*_____ Current Concepts in Systemic Diseases and the Macula
*_____ Diagnosis and Treatment of Cardiac Arrhythmias
*_____ Medical Genetics for the Practicing Physician
*_____ Panoramic View of Marital Therapy
_____ Ultrasonic Imaging in Radiology
*_____ What's New in Acid-Base and Fluid-Electrolyte Balance

Name (please print) ____
(last) (first) (initial)
Street ____
City ______________________ State ________ Zip ________

Please check one of the below:

_____ MSMS member _____ Non-MSMS member _____ Resident in training

Tuition schedule for courses:
MSMS members: $4 per credit hour, or $12 for each half-day course
Non-MSMS members: $8 per credit hour, or $24 for each half-day course
Residents and Interns: No charge

Luncheon reservations: The hotel will provide a luncheon each noon at $7 per person. Advance reservations are requested so MSMS can give the Detroit Plaza an accurate guarantee. Please indicate which days you want luncheon.

Tuesday lunch _____ Wednesday lunch _____ Thursday lunch _____

- Indicate total number of half-day courses _____ × $12 (or $24) = $ _____
- Number of luncheons requested _____ × $7 = $ _____
- Registration for special 16-hour ACLS Course ($115 incl. lunch) $ FILLE
- Total amount due MSMS $ _____

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823

MSMS leaders present views of PBB threat to state's citizens

MSMS leaders have been called on for comment in the recent political campaign controversy over the effects of PBB on Michigan citizens. A statement prepared by MSMS President Louis E. Heideman, MD, was released by Gov. William Milliken's office to put claims by challenger William Fitzgerald in perspective. MSMS Secretary Robert M. Leitch, MD, Battle Creek, was interviewed by WILX-TV of Lansing-Jackson, in an election preview. Both MSMS leaders talked of physicians' concern about PBB risk to citizens, the need for thorough study, and the inconclusiveness of evidence so far that PBB causes damage to humans.

MSMS offers workshop to help physicians who teach CME

Enrollments are being accepted now for a "seminar for CME program planners and instructors" to be offered by the MSMS Committee for CME Programming at MSMS headquarters the afternoon of Nov. 30 and all day Dec. 1.

This is the third in this series of seminars designed to introduce the latest techniques in program planning along with practical advice in how to improve lectures at hospital CME programs.

The seminar will provide 9 hours of Category I CME credit. The registration fee is $35 to cover the costs of materials and the honoraria for two MSU professors who will comprise the workshop faculty.

Please write to Katie Brewbaker, MSMS, 120 West Saginaw, East Lansing, 48823, for a registration form and further details.

MSMS task force distributes more medical cost guidelines

Practical Guides 3 and 4 to help contain health care costs went in the mail Oct. 2 to hospital chiefs of staff and component society presidents from the MSMS Task Force on Medical Care Costs. The guides, on discharge planning and outpatient surgery programs, respectively, will be printed in full in the November Michigan Medicine. Guides 1 and 2 appeared in the June issue of the MSMS journal.

CAPSULES/continued

AN EVEN SPLIT between those who favor Blue Cross/Blue Shield and those who would prefer other carriers for MSMS group health insurance programs was registered in a recent survey of MSMS members. The survey, conducted by the MSMS Bureau of Economics will be reported in detail in the November issue of Michigan Medicine.

* * *

MICHIGAN PHYSICIANS MAY BE AMONG 30,000 physicians nationwide to be contacted by three research firms for information in the National Medical Care Expenditure Survey. Data from the survey will be used to prepare HEW statistical summaries. Physicians who are contacted and who have questions may call a survey coordinator toll free at 1/800/225-1970.

* * *

THE FIRST "CALL FOR ACTION--Ask the Doctor" program will be conducted by Detroit radio station WJR Oct. 24 from 4 to 8 p.m. The public will telephone any questions regarding medical care to volunteer physicians at the station, who will help answer the questions or refer them on. The calls are not broadcast on the air. The service is planned as a monthly project and will follow the "Call for Action--Ask the Lawyer" format already established.

MSMS group term life insurance open enrollment fact sheet

$25,000 of group term life insurance available without evidence of insurability if . . .

* 300 MSMS members, under age 60, who have never been previously declined by the insurance carrier, and who are not already insured for the maximum amount of insurance under the MSMS group life program, enroll.

* The enrollment card below must be completed and received by Dec. 15, 1978.

* The annual PREMIUM for this $25,000 Term Life Insurance depends upon your age:

Thru 29	- $ 37.50	45-49	- $202.50
30-34	- $ 50.00	50-54	- $304.00
35-39	- $ 75.00	55-59	- $450.00
40-44	- $135.00		

* All coverage will become effective Dec. 15, 1978, provided 300 MSMS members under age 60 enroll. Send no money. We will bill you pro rata to the March 1 annual billing date.

* This coverage (the $25,000 open enrollment amount) is with the current, well-established MSMS group life plan underwritten by The Mutual Benefit Life Insurance Company of Newark, New Jersey. All plan provisions apply to the open enrollment amount.

* If you are disabled before age 60, your life insurance coverage is continued without further premium payments to age 70. If disability occurs between ages 60 and 65, your life insurance coverage is continued for one year without further premium payments.

* Payment to the beneficiary of your choice can be made in one sum or in a variety of forms of installment income. The right to change the beneficiary and settlement options can be exercised at any time.

* You are eligible to share in any dividends that become payable due to favorable group experience. It should be remembered that dividends are not guaranteed.

* If you discontinue your membership in the MSMS, you may be eligible to convert your coverage to one of many Mutual Benefit Life's individual policies (except Term) without evidence of insurability.

* You will be furnished an individual certificate of insurance which will summarize in more detail the policy provision.

OPEN ENROLLMENT REQUEST FORM
MICHIGAN STATE MEDICAL SOCIETY - GROUP TERM LIFE INSURANCE (G-1321-1)

NAME______________________________ SEX __ M __ F
(Last) (First) (Middle Initial)

MAILING ADDRESS______________________________
(Number) (Street) (City) (State) (Zip)

DATE OF BIRTH______________________ AGE______________
(Month-Day-Year)

BENEFICIARY______________________ RELATIONSHIP______________
(Print name as Mary Doe, NOT Mrs. John Doe)

______ I wish to request enrollment in the Group Term Life Insurance plan for $25,000. (If you are presently insured, in no event will your total amount of Group Term and Permanent insurance under this plan be more than $50,000.)

______ I would like information regarding additional Group Life insurance coverage.

HOW TO ENROLL: To enroll in the Group Term Life Plan, complete this request and mail to Stratton-Cheeseman & Associates, P.O. Box 1563, East Lansing, MI 48823.

Date______________ Signature of Proposed Insured______________________

This plan is underwritten by The Mutual Benefit Life Insurance Company, Newark, New Jersey • Kansas City, Missouri.

THE PROJECT MANAGER OF the new MSMS Physician HSA Support Center will begin work in mid-November. He is Dennis Paradis, a member of the Michigan House of Representatives Republican staff. He has worked on health and medical legislation and holds degrees from MSU and the U-M.

* * *

WILL YOU BE UNABLE TO VOTE in the general elections Nov. 7 because you'll be attending the MSMS Annual Scientific Meeting in Detroit? If you'll be out of town for any reason, you may fill out the application for an absentee ballot printed on page 535 of the October Michigan Medicine, present it to your township or city clerk, by the Nov. 4 deadline, and obtain your absentee ballot.

Inside this issue . . .
don't miss the forms for 1978 MSMS Annual Scientific Meeting registration, and for the special MSMS group life insurance open enrollment period.

MSMS study of malpractice claims shows 390 suits closed Dec. - Aug.

Three hundred ninety malpractice suits against physicians were closed in Michigan between December, 1977 and August, 1978. Data from those suits are now being compiled in the continuing MSMS survey of settled suits. The survey is updated every few months by the MSMS Bureau of Economics. The bureau draws its statistics from the closed claims reports required by law to be submitted to the Michigan Department of Licensing and Regulation. The reports are public information. Greater details of the MSMS continuing survey will be published in the December issue of Michigan Medicine.

Suggestions in to MSMS for UAW medical benefit talks

The Council of Specialty Societies will meet Oct. 19 to continue its review of suggestions by county and specialty societies, and individual physicians for the 1979 UAW negotiations with auto companies for medical benefits. The suggestions have been sought over the past several months by Blue Cross/Blue Shield of Michigan, with MSMS serving as a focal point for collection of the comments.

MD/Blues work group continues to me

The Physician/Blue Cross-Blue Shield of Michigan work group will meet for the sixth time Oct. 24 at MSMS headquarters. Progress continues to be made by the group, reports Donald K. Crandall, MD, Muskegon, chairman. The group has been meeting almost monthly since June to hammer out specifics of a service benefit program designed to help contain medical care costs. The group consists of four physicians and four BCBSM corporate body representatives, along with supporting staff.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 77, NO. 31 NOVEMBER 6, 1978

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CAPSULES

MSMS PRESIDENT Louis E. Heideman, MD, is making an excellent recovery from a heart attack suffered in August. He spoke late in October at the annual convention of the Indiana State Medical Association and attended the MSMS Council meeting Nov. 1.

* * *

APPROXIMATELY 150 telephone calls were received Oct. 24 by WCMS-MSMS members volunteering to help the public with medical care problems through the first WJR "Call for Action--Ask the Doctor" session. Concerned citizens may call the station during a four-hour period to speak with a physician about problems in receiving and paying for health care. The doctors refer the callers to others if necessary and have a detailed reference directory to helping agencies at hand. The calls are not broadcast. MDs at the first session were Archie Bedell, MD; Richard Ferrara, MD; Dale Kobernick, MD; Peter McCabe, MD; David C. Nolan, MD; and Kenneth J. Ray, MD, ll of the Detroit area.

* * *

ITH THE PUBLICATION of the ovember issue of Michigan edicine, MSMS members will ave help in their efforts to iscuss medical care costs ith patients. A special tent card" is included in he journal describing the hysician's concern with ising costs. The card may e removed easily for display n the office reception area. xtra copies are available rom MSMS headquarters.

MSMS Council highlights

On Nov. 1, The Council:

1) Approved the 1979 MSMS budget, with projected operating income of $1,682,975 and projected annual expenses of $1,723,113. The new budget reflects an anticipated 1.9 percent increase in income, and an anticipated 1.3 percent increase in expenses. The items included in the 1979 budget are relatively unchanged from the 1978 budget, except for the addition of the new MSMS HSA/Physician Support Center. The Finance Committee reported that a $5,000 to $10,000 surplus is expected by the close of the current fiscal year, instead of the anticipated $105,000 budget deficit.

2) Approved MSMS printing of folders on medical care costs and health facts and figures to be made available at cost to MSMS members for patient distribution.

3) Heard a report from the advisory committee to MSMS legal counsel on the status of MSMS litigation. MSMS is a) pursuing the otolaryngologists' suit with the Blues on appeal; b) continuing the psychiatric suit in Oakland county; c) monitoring the National Pharmacy Case before the U.S. Supreme Court, and d) implementing the amicus curiae suit in support of Doctor Friedman.

4) Offered suggestions to the Council of Specialty Societies after reviewing recommendations gathered for implementation in the United Auto Workers medical benefit programs to be negotiated in 1979.

Special MSMS group life open enrollment period underway

Have you taken advantage of the special open enrollment period underway through Dec. 15 for MSMS group life insurance? Any MSMS member up to age 60 may sign up for $25,000 of insurance without proof of insurability, if 300 members in total sign up. A form for enrollment appeared in the Oct. 19 issue of Medigram. Information is available from administrator Stratton-Cheeseman and Associates, Inc., P. O. Box 1563, East Lansing, 48823, toll-free tele: 1-800-292-2136 (locally 351-5780).

CAPSULES/continued

AS A RESULT of the enactment of the new Michigan Public Health Code, the Medical Practice Board has been renamed the Michigan Board of Medicine.

* * *

A NEW FEATURE reporting progress and programs of the Michigan Physicians Mutual Liability Company is making its debut in the November issue of Michigan Medicine.

* * *

MSMS MEMBERS TAKING the public's questions on the Nov. 7 segment of Channel 56's "Housecall" include Bruce Danto, MD, Detroit psychiatrist and Mario Petrini, MD, Detroit obstetrician-gynecologist. The next "Housecall" program will be televised Dec. 5. Guests then will include Arnold Weissler, MD, WSU internal medicine department head, and Harold Kendricks, MD, Pontiac family physician. The live phone-in shows are cosponsored by MSMS and the Wayne, Oakland and Macomb county medical societies.

'Doctor-of-Week' program changes will allow more MDs to take part

Revisions in the nine-year-old "Doctor-of-the-Week" program were accepted by The Council Nov. 1. The updated program will retain physician representation in the Capitol Building in Lansing, but flexibility will be added to allow a greater number of physicians to take leave from their practices to participate. Computerized programming will be employed to take advantage of physician expertise and legislative contacts developed by the various doctors-of-the-week. Short one- and two-day visits will be intended to acquaint more physicians with the legislative process, and more legislators with MSMS members from throughout the state.

MSMS preparing responses to preliminary State Health Plan

MSMS responses to the Preliminary State Health Plan are being coordinated by the MSMS Health Planning Steering Group, Kenneth J. Ray, MD, chairman. The new group met Nov. 1 to also discuss the operation of the new MSMS Physician/HSA Support Center. MSMS responses to the PSHP will be voiced at state hearings this month around the state. The 760-page preliminary plan is described in a November Michigan Medicine article, with the entire four-page special section of the December journal to be devoted to MSMS responses to potentially powerful proposals.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

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CAPSULES/contir

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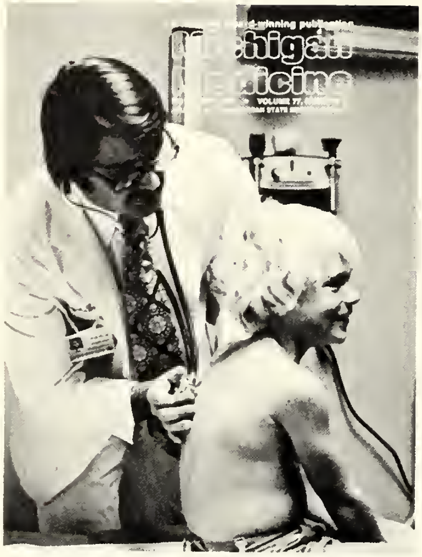

The Michigan Academy of Family Physicians and the state's three medical schools are committed to producing more of the much-needed primary care specialists. See special section pages 589-592, and related article page 621.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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Michigan Medicine, **the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**

Michigan Academy striving to provide well-trained family physicians

By Gordon W. Willoughby, MD
Frankfort

For more than 30 years the American Academy of General Practice/Family Physicians has been the leader in the development of continuing medical education for the practicing physician.

A minimum number of CME hours has always been a qualification of membership in the AAFP, as have specific educational requirements for continued membership. These requirements have recently been adopted as innovations by other societies, and many states are now mandating similar CME requirements as the basis for continued licensure.

The AAFP has a large Education Commission, which is one of its busiest commissions. It is concerned with the development of programs, and oversees and monitors the quality of CME programs put on by its component chapters. Frequent seminars are held on the development and execution of the CME programs.

MAFP a leader

Over the past 10 years, the Michigan Academy of Family Physicians has become a leader in the development of practical, worthwhile programs for the practicing physician. The MAFP has worked hand in hand with the University of Michigan in the development of all its family physician-oriented programs. MAFP has had direct participation in the content and selection of instructors for the U-M programs. This illustrates the point that in order for a program in Michigan to be approved for AAFP credit, then the program must have some active participation by the Education Commission of the MAFP. The demands on this commission have expanded tremendously the past few years, as we strive to promote only worthwhile programs.

During the past 10 years, the MAFP has put heavy emphasis upon the development of full departments of family practice by all the medical schools in Michigan.

This has been considered essential to the future growth and development of family practice. The academy believes it is so important that medical students become exposed to good, inspiring role models during the early days of their training, and continuing to their graduation. The academy has combined its work toward university family practice departments with organizing preceptorships with family physicins throughout all geographic areas of Michigan. This program has had a very positive effect upon the medical students. MAFP is pursuing new sources of funding for this important program. Students have been very happy with their exposure to actual practice away from the medical school atmosphere and wish to see continuation of the preceptorships, also.

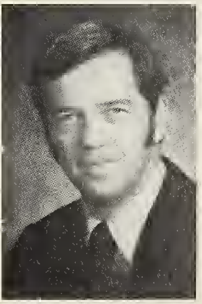
Residencies are growing

During the 1970's, we have seen the development and approval of totally new family practice residencies. These have been designed to cover the entire scope of continuing, comprehensive health care for the whole family unit. Health maintenance and preventive care receive a large emphasis in these programs, which are turning out very well-trained, capable family physicians in increasing numbers. The most recent residency program approved is in Marquette and will provide many needed family physicians to the upper peninsula. The upper half of the lower peninsula also needs to be served by a family practice residency program to provide physicians to a large, underserved area of Michigan.

As part of the rapid development of these family practice programs, there has been an increasing need for well-trained family practice teachers. The AAFP and MAFP have several teacher development and training programs throughout the year. We must have well-qualified, dynamic teachers to attract the students we want into our family practice residency programs.

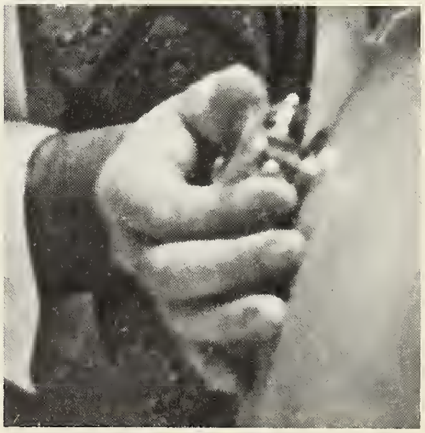
The public is demanding comprehensive family medicine and we are striving to provide well-trained physicians to fill this need.

Doctor Willoughby is president of the Michigan Academy of Family Physicians.



Doctor
Willoughby

See related article in "Views" section, page 621.



MSU Department of Family Practice strives to practice what it teaches

By Roy J. Gerard, MD
East Lansing

The Department of Family Practice at Michigan State University is alive, well, and continues to grow and have a significant effect on the education of students in the College of Human Medicine.

The greatest priority of the department is to continue developing the family practice model of care in the Clinical Center so as to expose both the students and in particular, the other specialty departments, to what family practice is all about. It is of the greatest significance that we practice what we teach.

New growth abounds

The department continues to grow as new resources are developed. In June of 1978 the department was reorganized in the following divisions: an Undergraduate Division with Robert Landick, MD, director; a Graduate Division with James O'Brien, MD, director; a Division of Clinical Services with David Hough, MD, acting director; and a Research Division with the director yet to be chosen. Paul Werner, MD, is the director of the Undergraduate Division in the Upper Peninsula Medical Education Program. In June 1978, 10 medical students graduated from this program.

The department has had a greater percentage of faculty involvement in Phase I and Phase II than any other clinical department in the College of Human Medicine at Michigan State. We have developed a course entitled "Introduction To The Family" and a series of videotapes that are presented to small groups of students which orients the first year medical student to the family as a unit of care.

In Phase III, the department is developing a pilot program for a continuing family practice experience. The pilot models consist of one in Flint, Kalamazoo, and Williamston. An experimental rural family practice clerkship experience is being developed in Alpena with a target area for the rural underserved area of Alcona, Presque Isle, Montmorency, and Oscoda counties.

In graduate education, a joint but separate residency program has been developed with St. Lawrence Hospital in Lansing and there are presently five residents involved in this program. There are four residents at the first year level, one at the graduate level. Dwight Schroeder, MD, is the director of the St. Lawrence Hospital program. James O'Brien, MD is the director of the MSU program.

An affiliation agreement has been approved by Bon Secours Hospital and the College of Human Medicine. One is being developed for Marquette and Midland. It is anticipated that an affiliation agreement defining the relationship of the department with all of the communities will be developed this year.

The Family Practice Department had a very successful Research Day in 1977. It was the first of its kind in the country. We will be sponsoring Research Day II on Nov. 2, 1978. In addition, the research division of the department will be developed during this year.

The department continues to develop new sources of funding and this will be the first year in which the Kellogg Foundation is not the main funding organization. The department is indebted to the Kellogg Foundation which has over the last four years contributed over $824,000. We most recently received a grant from Health Education and Welfare for five years for the joint family practice residency program. The department is participating in a grant for faculty development which is administered through the Office of Medical Education Research and Development and the College of Osteopathic Medicine. This will give us an opportunity for family practice faculty development at three levels: 1) residency; 2) community; and 3) fellowships.

An indigenous core

It is our goal to prove through our curriculum that we are not just a derivative discipline but we have an indigenous core that is ours, and to continue to urge that the family practice educational and political organization consider the family as a unit and object of care — not just a patient in context of family.

The Department of Family Practice at Michigan State University was one of two medical schools in the country to be highlighted during the Jan. 3, 1978 NBC Television special, "Medicine in America." By taking part in this special, it is the Department's hope that a contribution was made toward educating the public as to what family practice is all about.

The future of American medicine is bright, and family practice can play the pivotal role in developing a health care system that will meet the needs of all people of this country. We must be more aggressive, we must be less rigid, and we must have more vision.

Doctor Gerard is professor and chairman, Department of Family Practice, MSU College of Human Medicine.

Doctor Gerard

Wayne's FP program gratified with indications of good results

By Joseph W. Hess, MD
Detroit

Doctor Hess

There is an old Chinese proverb which says, "Patience is power; with time and patience the mulberry leaf becomes silk." True to the wisdom of this proverb, patience and careful nurturing have brought family medicine to its current level of development at Wayne State University.

Some history

The early groundwork for family medicine at Wayne was laid by former Deans Gordon Scott and Ernest Gardner in the late 1950's and throughout the 1960's. Curriculum committee recommendations led, among other things, to creation of a family and community medicine rotation for third year medical students in 1970. Shortly thereafter, the Department of Community and Family Medicine was organized under Doctor Ruben Meyer's leadership. Over the next two years, in addition to teaching medical students, the department helped organize and obtain federal funding for the Michigan Cooperative Primary Care Preceptorship Program which includes more than 300 physicians throughout the state. A family practice residency application was prepared in collaboration with Grace Hospital and approval received in December 1973.

In 1974, soon after Doctor Meyer's resignation, division of Family and Community Medicine into two separate departments occurred, and recruitment of a new chairman and family physician faculty was accelerated.

The four years from 1974 to 1978 were tumultous, to say the least. Physicians accustomed to the speed and simplicity of management decisions in private practice had great difficulty understanding why the wheels of a university bureaucracy turn so slowly and why resolution of problems takes so long. Medical Center hospital staffs were very cautious about granting medical staff privileges to faculty family physicians. Some faculty and residents in established departments were vocally skeptical about the wisdom and viability of family practice as a new academic discipline and field of practice. This, along with the social and economic blight which Detroit experienced during the 1960's and 1970's either discouraged many students from seriously considering family practice residency training or led them to seek it in friendlier, more pleasant settings in suburban and small communities throughout the state and elsewhere.

Some results

These early years were trying times for all of us who carried responsibility for developing family medicine at Wayne. However, persistence is paying off, the storm is subsiding and we are beginning to see some of the results we have been working for. Here are a few of the indicators at the beginning of the 1978-79 academic year.

— Nine full time and 66 clinical faculty, along with physician preceptors, are providing instruction for over 800 medical students each year.

— The family practice residency has grown from five residents in 1975 to 22 in 1978-79. The goal is a total of 60 by 1985. Seven residents have graduated, and all but one of them have initially settled in Michigan.

— The department has organized CME programs specially designed for family physicians several times each year since 1974.

— Since 1975, the department and the directors of the seven family practice residencies in metropolitan Detroit have been meeting monthly and co-sponsoring education activities for all family practice residents in the Detroit area.

— A second Family Practice Center is scheduled to open in 1979 near Grace Hospital in northwest Detroit.

— Preliminary discussions are ongoing with several other hospitals in the southeastern part of the state who have expressed desire for a closer working relationship with the department and WSU School of Medicine with the common goal of promoting family practice education.

— An affiliation with the Beaumont Hospital system has been approved by the University's Board of Governors for the purpose of establishing another unit of the Department's residency program in Troy.

Key issues

The most difficult pioneering period for the family practice movement nationally and at Wayne seems to be drawing to a successful conclusion; however, there are many key issues which will be of continuing concern. These include educational program financing, recruitment of increasing numbers of high quality faculty and residents, and the constant need to upgrade the quality of education, patient care and research.

Many people and organizations deserve credit for what has been accomplished at Wayne. The list includes the family physician faculty who were willing to help pioneer in the difficult early years; the Michigan Academy of Family Physicians who lobbied effectively for legislative support; Dean Robert Coye and his associates who have supported the department's growth; and very importantly, family physicians throughout the state who have given Wayne students a first-hand look at the challenge and opportunities of family practice.

Patience and persistence are paying off. The mulberry leaf is starting to become silk.

Doctor Hess is chairman, Department of Family Medicine, Wayne State University School of Medicine.

U-M has newest Michigan department of family practice

By Terence C. Davies, MD
Ann Arbor

In November of 1976, the Board of Regents of the University of Michigan formally endorsed the establishment of a Department of Family Practice at the University of Michigan Medical School. In this way, the third of Michigan's three medical schools officially acknowledged the new specialty of family medicine as an important academic discipline worthy of support and promotion.

U-M department developing

During the first eight months of its existence, this new department has managed a number of accomplishments.

Student interest in family practice at the University of Michigan is at a very high level, and the staff has assisted me in providing students with information concerning family practice and family practice residencies, arranging interviews, and writing many letters in support of students to programs around the country.

Our own residency is dependent upon the outcome of an application for accreditation which was completed and submitted in August. If approval is granted, we will take our first residents in July, 1979. Although this schedule will exclude us from the National Residency Matching Program, I have high hopes we can identify a number of enthusiastic and well-qualified students who will join with us in making a beginning. Ultimately, the program proposes to have 12 residents per year, for a total of 36.

The Family Practice Center is located in the neighboring township of Chelsea where, through a lease agreement, the University of Michigan has acquired a busy on-going medical practice. A director of the Family Practice Center was appointed in July with three additional family physicians being appointed as faculty in July and August. At the present time, the five of us, with some support from local private physicians, are doing our best to provide for patient-care needs while also working to re-design certain aspects of the practice for educational purposes. Eventually, as residents are introduced, the physicians on faculty will become team leaders who will maintain their own limited patient practices, and also will have major responsibility for teaching, research, and administration.

Faculty being recruited

To ensure the quality of our emerging educational programs, a professional educator was recruited and appointed as one of the first members of departmental faculty. Designated the "director of educational development," this faculty member has the singular responsibility of ensuring that all learning opportunities sponsored by the department have well-designed goals.

Further additions to faculty may include scholars in medical fields related to family practice such as genetics and epidemiology. Specialists in the newer areas of gerontology and the human life-cycle may also be recruited and there is a need for a person with special expertise in the behavioral area.

There is no precise blueprint available for the design of a new department of family practice, but the thrust is to secure individuals who can collectively demonstrate excellence in the four broad areas of academic activity: namely, clinical practice, teaching, research and administration.

Doctor Davies

I have an admittedly biased but strongly held conviction that family practice represents the logical "hub" and focal point around which all medical education should be constructed.

Family physicians' perspective

The generalist's personal and comprehensive viewpoint of patients and disease, particularly in the context of the family, is a perspective which has meaning and significance for all medical students and residents. Such an orientation has the potential of adding relevance throughout the medical school curriculum and is complementary to other specialties which, ideally, depend upon the generalist for his initial analysis of clinical problems and their appropriate referral.

Academic institutions bear the heaviest of responsibilities in determining and developing the intellectual heritage to be passed on to future generations. As a newly-arrived but now-equal member of academe, family practice has a full share of this responsibility.

We have brought fresh emphasis to the practice of humanistic medicine and the total health-care needs of our patients. We must now proceed to define and describe our knowledge and competencies.

Throughout our past decade of evolution, we have relied upon the primary disciplines to assist us in teaching clinical competency.

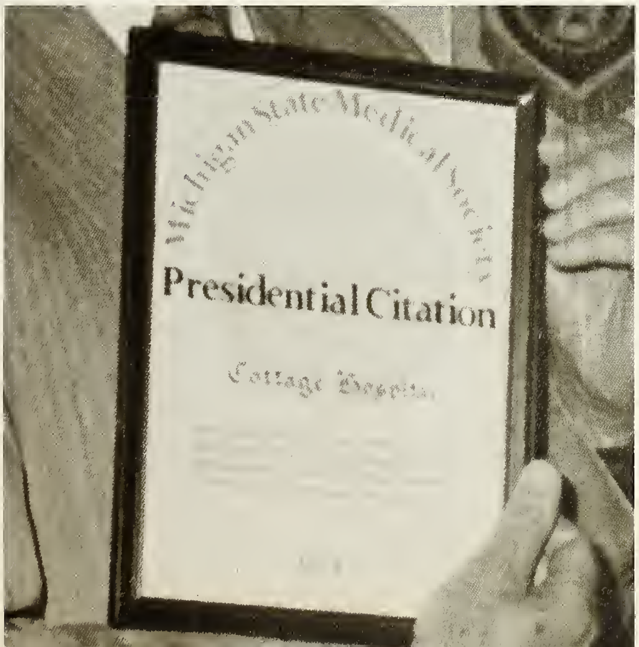
Building upon this foundation, the challenge facing us now is to demonstrate to them and to our medical students that we all share equal standards of excellence and precision and are capable of practicing and teaching our unique discipline according to the best academic traditions.

Doctor Davies is professor and chairman, Department of Family Practice, University of Michigan Medical School.

MSMS honors long-time AMSA-MECO participants

Past President Robert M. Leitch, MD, presents MSMS Presidential Citations to two Battle Creek hospitals. At left is Dan Munzer, assistant administrator, Leila Post Hospital, and Mary Staten, Kalamazoo, WSU medical student who participated in the AMSA-MECO program. To Doctor Leitch's left are Walter J. Bell, Community Hospital administrator and Robert Couch, chairman of the hospital association Board of Trustees.

R. Duane Nimke, assistant administrator of Grayling's Mercy Hospital, left, accepts the MSMS Presidential Citation from Mert Scholten of the MSMS Department of Communications. AMSA-MECO student Daniel Hull from the University of Michigan Medical School looks on.



Michigan State Medical Society

Presidential Citation

Cottage Hospital

James Danforth, MD, holds the Cottage Hospital AMSA-MECO Presidential Citation as he makes the presentation on behalf of MSMS President Heideman to John H. Williams, MD, medical director of the program and Ralph Wilgarde, Cottage Hospital Administrator.

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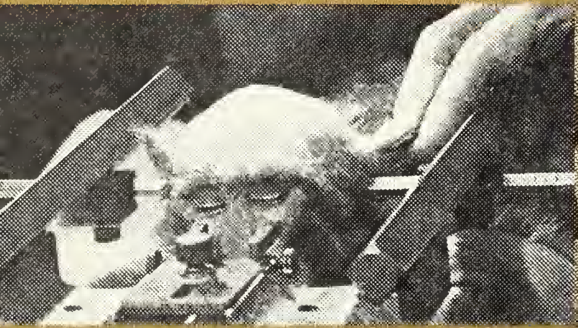

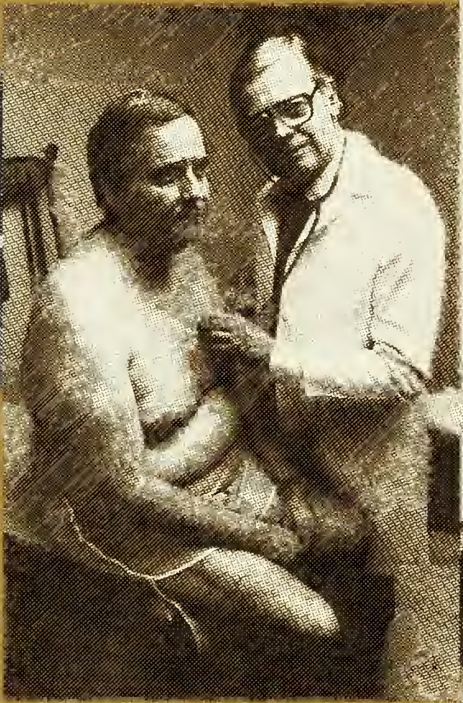

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Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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MSMS/A

Auxiliary emphasizing long-range planning

By Nell Rhoades
Detroit

With an AMA/A suggestion that state auxiliaries form a long range planning committee, Michigan's auxiliary now has taken this important step.

This new standing committee has been formed involving members on a two-year rotating basis. They include a chairman, the auxiliary president, president-elect, vice-president, past president, editor, plus the chairmen of membership, communications, and convention committees.

Planning is a process through which present programs are analyzed! The national auxiliary stated, "It is deciding in advance what is to be done, how it is to be done, who is to do it, and what is to expected as a result. A good way to accomplish this is to set up a committee to study and evaluate auxiliary procedures, future objectives, and projected resources as they relate to your purposes." — and that is the purpose of this committee!

Based upon a question sheet prepared by the AMA Auxiliary, a questionnaire was drawn up for our LRP committee to study and evaluate, the results to be compiled, and the questionnaire then presented to county auxiliaries. Their answers would help indicate in what direction(s) they would want long-range planning to go to insure continuity, to set priorities, to be aware of needs and/or problems that might arise, and how to be more effective and productive in achieving auxiliary goals and purposes.

On the national level, a result of their long-range planning survey brought about a Health Projects Committee to replace the Project Bank Committee — the name change reflecting a broadening of the committee's duties to include promotion of health education in general.

With members' help and cooperation, the long range planning committee hopes to develop a profile of auxiliary activities, to recognize existing gaps, as well as to become aware of the overlapping of services and activities.

Mrs. Rhoades is chairman, MSMS-A Long-Range Planning committee.

Mrs. Rhoades

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MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

For: A. Stewart Kerr, MSMS Counsel

"Why don't Michigan doctors organize as a union?"

Federal laws permit only persons who are "employees" to organize as members of a labor union. Physicians, for example, who are employed by a hospital, clinic, or as medical director of a large corporation could organize a labor union to negotiate with these employers. However, Michigan physicians as a group are mostly self-employed and are not employees of any one employer, and therefore cannot organize as a union — there is no one to negotiate with.

For: John R. Wilson, MD, President
Michigan Board of Medicine

"The new Michigan Board of Medicine form physicians are using this fall to report mandatory CME credits provides the opportunity to report Category I activities with a 'tutor.' Would you please clarify the conditions which apply under this classification? Does this mean a physician can claim credit if he or she spends a day or two with a professor observing at a hospital?"

The answer to approval of a couple days spent with a professor lies in the physician getting prior approval from the Michigan Board of Medicine. The Michigan Board of Medicine requires the physician to submit a proposed program of work with a tutor to the board for approval, indicating how many hours the physician believes the work is worth. The board must approve the work for credit prior to the physician's commencement of the work. The classification of work with a tutor for Category I credit is part of the new CME rules and regulations just approved Oct. 3 by the Joint House and Senate Administrative Rules Committee.

"There is still some confusion regarding the new 150-hour requirement for CME. The question is, does the new 150-hour requirement for a three-year period mean this counting starts in 1978 and continues for each subsequent three-year period? In other words, will we need 150 hours for 1978-80, and 150 hours for 1981-1983, etc.?"

No, the new CME law (PA 123, 1978) requires each physician obtain at least 150 CME credit hours in the three years preceding the year he or she is requesting licensure. This means, for example, if a physician is applying for a 1979 license, he or she must be able to document having obtained at least 150 CME credit hours during the period 1976-77-78. If applying for 1980 licensure, the physician would have to have obtained the 150 hours in the three-year period 1977-78-79, and so on.

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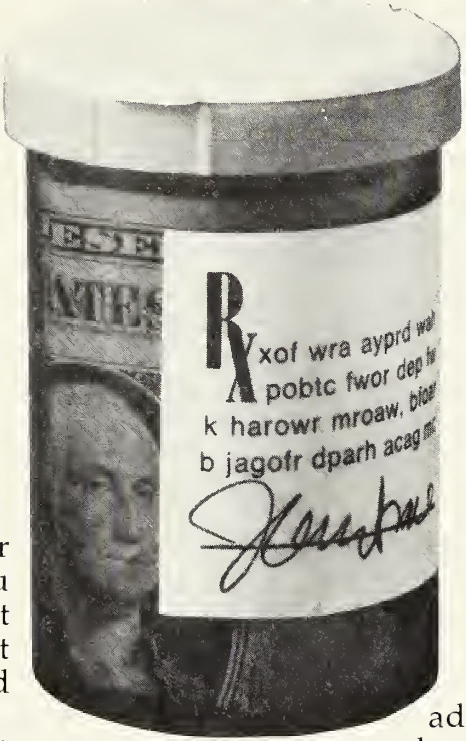

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The Preliminary State Health Plan

— you've heard of its ominous 760 pages; here's MSMS view of its significance

By Sherry N. Wellman
MSMS Government Agency Liaison

This month, the MSMS Health Planning Steering Group has directed official responses to major segments of the Preliminary State Health Plan for presentation at public hearings.

To keep Michigan physicians informed as this process is underway, this article describes the basic form of the Preliminary State Health Plan, its origins and points of special interest to doctors. Articles planned for the December issue of *Michigan Medicine* will describe MSMS official response to the plan, with comments by Kenneth Ray, MD, chairman, MSMS Health Planning Steering Group.

Changes in the health care delivery system may be more extensive in Michigan than anywhere else in the country. State agency health planners here are initiating a more encompassing scope of changes than currently is underway in any other states.

Their enthusiasm is embodied in the 760-page Preliminary State Health Plan now under consideration.

PL 93-641 calls for each state to prepare a State Health Plan to be used as a basis for state and federal resource allocations for health-related programs. The law delegates the preparation of a preliminary plan to the designated state health planning agency which in Michigan is the Office of Health and Medical Affairs (OHMA).

This staff-prepared document is then to be reviewed, modified and altered until it meets with the approval of the Statewide Health Coordinating Council (SHCC), the Legislature and the Governor. The process includes wide distribution of the preliminary plan for public comment and public hearings so that eventually the state has a guide for making decisions to meet the public's health needs.

MSMS active

The Michigan plan is at the stage of public hearings with SHCC formal action scheduled for December.

To assure the views of Michigan physicians are heard, the MSMS Health Planning Steering Group has directed official responses to major segments of the Preliminary State Health Plan for presentation at public hearings.

In addition, physicians serving on HSAs, the SHCC, representatives of specialty societies and MSMS staff have actively monitored development of the preliminary plan throughout the summer and fall.

Traditionalists might have expected a preliminary health plan to deal with goals, objectives, proposed policies and recommended actions in such areas as cancer, heart disease, mental illness and substance abuse. Indeed, the plan does. The plan addresses 10 such major "health status" problems and contains 75 related recommended actions which account for some 200 pages of the document.

Another 60-plus pages deal with the four general environmental issues of housing, radiological substances, food supply and toxic substances. Neither the health status nor environmental portions of the preliminary plan have generated much controversy. However, there are 370 pages in the plan dealing with what are termed "health systems" issues. These pages have generated intense controversy and contain recommended actions to drastically alter health care delivery in this state.

OHMA tackles systems

When the OHMA staff drafted the health systems portions of the plan, they surely realized the controversy which would result from the associated recommended actions. In fact, quite an extensive rationale is given to explain why the preliminary plan places more emphasis on changes in health systems than on health itself.

The relevant section first quotes the statutory purposes of health planning: (1) to improve the health of the residents of the state; (2) to increase the availability, accessibility, acceptability, continuity and quality of health services in the state; (3) to restrain increases in the cost of providing health services; and (4) to prevent unnecessary duplication of health services.

OHMA then goes on to state, "In analyzing these purposes, it is important to recognize the implications for planning of the distinct delineation of concern for the health of the citizenry and concerns for aspects of health system performance. The purpose would appear to indicate that not only is planning for the improvement of health appropriate, but planning changes in the health system to improve efficiency, distribution of services and resources, etc., is also legitimate. This would certainly be consistent with the 'right to health care' theme of the overall mission of the planning system — to achieve equal access to quality health care at a reasonable cost."

The draft Preliminary State Health Plan addresses seven health systems problems. Those are: (1) health education services, (2) health personnel resources, (3) emergency medical services, (4) long-term care services, (5) health care costs, (6) specialized institutional services, and (7) financial barriers to care.

For those seven areas, the OHMA staff generated 98 recommended actions to effect changes. Some of the recommendations call for legislation to mandate change; others direct third-party payers to implement changes in methods of reimbursements and benefits, and still others encourage change through cooperation of private and governmental parties.

SHP has broad scope

Although a complete listing of the important proposed policies and recommended actions is not feasible, the scope of their effect can be judged from partial distillation. The draft Preliminary State Health Plan calls for the following actions: Limitation of medical school enrollments, limitation of residency positions in hospitals, alterations in reimbursement mechanisms to effect physician choice of specialty and practice location plus expansion of "primary care providers other than physicians." It should be noted that these recommended actions stem from a SHCC-adopted goal that "Michigan should have a supply of health personnel which is adequate to meet the needs of the state's residents."

Other recommended actions call for mandatory second opinions, lower reimbursements for unnecessary procedures, caps on reimbursements for hospital-based radiologists and pathologists, possible rate-setting mechanisms for physician reimbursements tied to total health care costs of a region, and caps on capital expenditures for hospitals.

If not amended or disapproved by the SHCC, these and other recommended actions are to be carried out by 1983. The entire state health plan is to serve as a guide for making all types of decisions related to Michigan's health system whether it be legislation, departmental budgets and programs or how private business is carried out in the state.

Providers' influence unclear

Whether the opinions of those most directly affected by the Plan's approach, namely the physicians and providers of medical care, will have any influence on the final document has yet to be determined.

It would appear that thus far health planners in Michigan have chosen to ignore another section of the federal law which should be given equal consideration. That section under the Congressional findings and purposes of PL 93-641 reads: "Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels."

Here are third and fourth guides on cost awareness from MSMS task force

(Guides 1 and 2 were printed in the June 1978 issue of Michigan Medicine. Each of the guides is the work of the MSMS Task Force on Medical Care Costs, chaired by Frederick W. Von Duyne, MD, Flint. The committee, composed of 13 physician members of MSMS, has been working to develop practical guidelines to assist Michigan physicians in helping contain health care costs. The guidelines are mailed to hospital chiefs of staff and presidents of component medical societies.)

Practical Guide #3: Discharge Planning

Description:

Discharge planning is a program to provide for continuing care and follow-up of patients after discharge from the hospital under the direction of their attending physician. A well-developed program can shorten the time a patient must stay in the hospital, and it can help provide appropriate care at less expense than if the patient stays in the hospital until all needs are met.

Objectives:

The objectives of a discharge planning program are:

A. To reduce the cost of hospitalization by shortening the length of stay.

B. To provide continuity of care to patients after discharge from the hospital.

Methodology:

A. The medical staff and administration should evaluate the hospital's present discharge planning program, and recommend revisions where appropriate. Consideration should be given to concerns such as:

1. Does the discharge planning program meet the standards of Professional Standards Review Organization; Joint Commission on Accreditation of Hospitals?

2. Do present hospital practices provide for review and referral of patients to home care programs, long-term care facilities, or other after-care programs?

3. What community resources are available for referral?

4. What is the current system for identifying and referring patients needing services after discharge?

5. What personnel is available to handle discharge planning? Should a coordinator be appointed, or can the duties be assigned elsewhere?

6. Are adequate funds provided for in the hospital budget to maintain the discharge planning program?

7. Is a procedure in use to monitor the discharge planning program?

Practical Guide #4 appears on page 604.

B. Physicians should know what hospital personnel are involved in the discharge planning process, so necessary care following hospitalization can be arranged efficiently and effectively in accordance with each physician's recommendations.

C. Physicians should help design new or improved hospital discharge planning programs, and offer advice on ongoing programs.

1. Physicians should be involved in defining the criteria for initiating timely discharge planning, and identifying categories of patients usually requiring special attention, such as:

a. Patients with chronic illnesses, especially multiple illness.

b. Terminally ill patients.

c. Pediatric patients with social problems, such as parent rejection or battered child syndrome; newborns who are premature or have congenital malformations, birth injuries, unusual weight problems, or acute or chronic disease.

d. Maternity patients with chronic diseases, malnutrition, physical handicaps.

e. Surgical patients requiring prolonged convalescent period.

f. Geriatric patients.

g. Emotionally disturbed patients.

h. Patients without families who need convalescent care.

i. Patients in poverty groups.

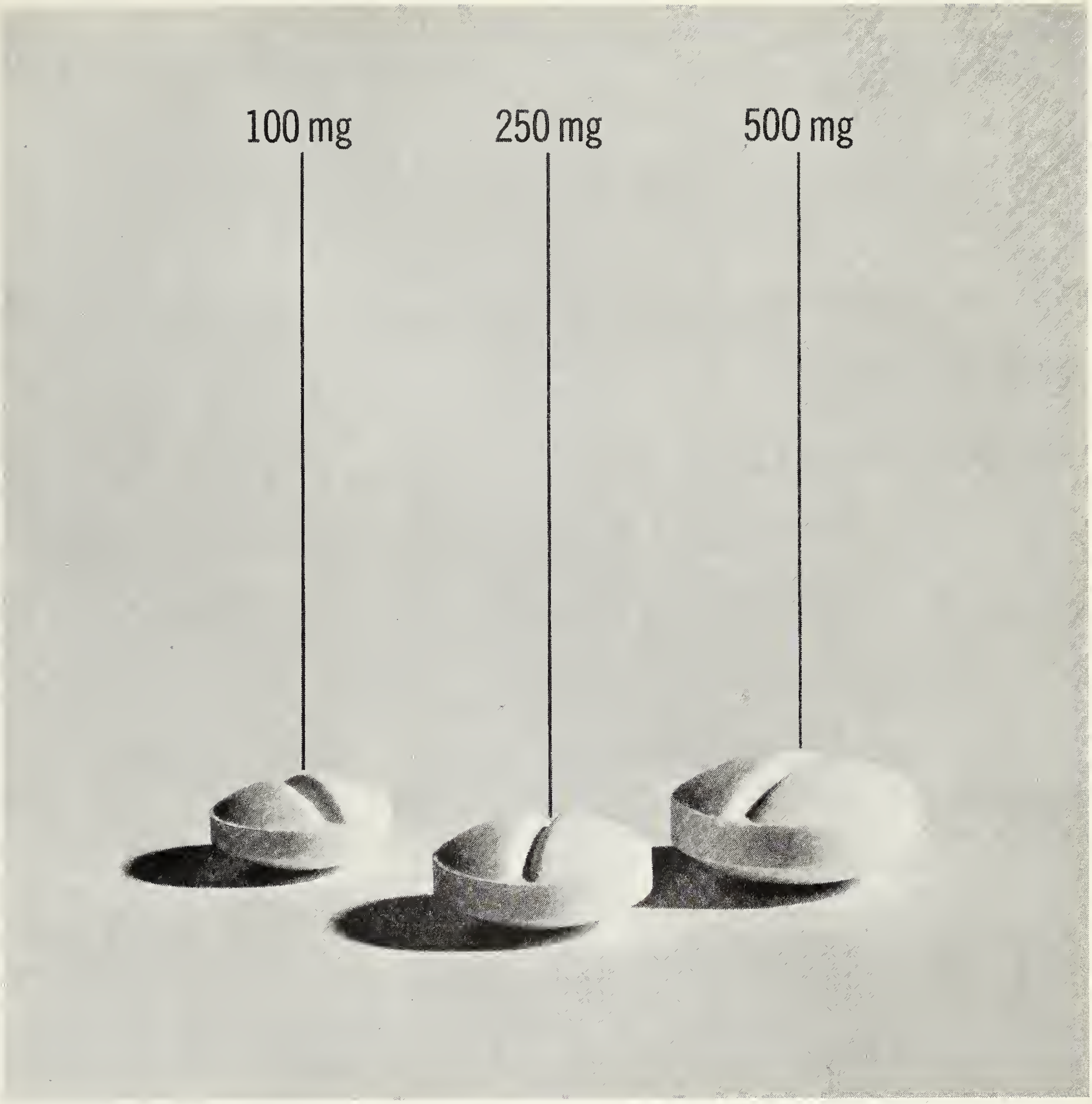
j. Patients with fractures.

2. Physicians should help identify situations where discharge planning can be requested by persons other than physicians subject to physician approval, such as:

a. Patient for family.

b. Nursing, respiratory, dietetic, or other hospital ancillary service.

c. Social service.



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Practical Guide #4: Outpatient Surgery Program

This is the fourth in a series of practical guides developed by the MSMS Task Force on Medical Care Costs to assist local hospital medical staffs in developing cost effective strategies and programs. The Task Force was authorized by the 1977 MSMS House of Delegates to develop methods of practice to assist in containing the costs of health care without compromising quality medical care. While the Task Force is mindful of the complexities involved in controlling the increase of medical care costs, it believes that physicians can attack the problem by continuing to initiate and support cost-savings activities at a local level.

Description:

Outpatient (ambulatory) surgery is defined as the performance of surgical procedures that, because of certain characteristics and risk potential, can be performed on an outpatient basis, with ambulatory convalescence.

Objectives:

The objectives of an outpatient surgery program are:

A. To increase efficiency and utilization of hospital surgical units.

B. To reduce the cost to the patient (or third party payor) by eliminating the need for in-patient hospital convalescence for certain types of surgery without compromising patient safety.

C. To free hospital beds for more seriously ill patients, and reduce waiting time for some elective surgery.

Methodology:

A. The medical staff and administration should review the feasibility of initiating an outpatient surgery program, or expanding an existing program. The review should include such concerns as:

1. Overall suitability for particular hospital and community.

2. State and county public health codes and regulations.

3. The hospital's general economic situation.

4. Current rate of bed occupancy and utilization of surgical units.

5. Amount of additional space and personnel needed for program.

6. Reimbursement policies of major health insurers.

B. The medical staff and administration should review the types of cases considered suitable for outpatient surgery. The most common procedures performed on an outpatient basis are tonsilectomies, ear surgery, eye surgery (removal of cataracts, correction of crossed eyes), hernia repair, hemorrhoid repair, closed reduction of fractures, bladder and kidney cystoscopy, vasectomies, plastic surgery, face lifting, nose corrections, hand surgery, full teeth extraction, varicose veins, breast biopsies, etc.

C. Physicians should encourage outpatient surgery programs through:

1. Medical staff discussions.

2. Medical society programs to seek modification of governmental regulations that discourage the development of outpatient surgery problems.

3. Public education.

4. Patient education.

D. Physicians should explore the feasibility of establishing Surgi-Centers (free-standing facilities for outpatient surgery) in their communities to bring down the cost of minor surgical procedures.

MSMS task force developing medical costs materials for patients

The Task Force on Patient Education Folders, chaired by Clyde E. Flory, MD, Lansing, has recommended a series of materials on medical care costs to be made available to physicians for distribution to their patients.

Step one will be the printing of a tent-type card that can be placed in the doctors' offices telling patients that their physician is aware of medical costs and how the physician is actively seeking to reduce the costs where feasible. The first of these cards is bound into this issue, facing this page. It may be easily removed for use in the physician's office.

Later, a folder of material on general cost awareness will be developed. The third phase of this patient educational campaign will be the preparation of small envelope stuffers, using the theme, "Did you know . . . ?" followed by a short economic comparison such as "Did you know while medical care costs have risen 186 percent on the 1967 price index, the cost of a pair of jeans has risen 197 percent during the same period?" (figures used are not necessarily precise in this example). The inserts could be enclosed in doctors' monthly billings. Physicians will be urged to obtain a supply of the folders which may be distributed to the patients and read at their leisure.

More information on this project will be made available to you soon.

COMPATIBILITY

Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®

(ISOXSUPRINE HCl)

20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his next breath...

he's active he's effectively maintained on

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Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

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Countervoints:

Health care delivery today, as seen by:

a regional Medicare director

(This article is reprinted, with permission, from the Journal of the Medical Association of Georgia.)

By Douglass M. Richard
Atlanta, GA

As a life-long practicing bureaucrat (GP, that is, not a specialist), I have available to me all the statistics one would need to fill up not just this one article but rather this entire issue. The things I could "prove" by use of these stats run the gamut from A to Z, and also from Z to A.

I could "prove" for example, that physicians are the cause of the horrendous annual increases in health care costs. I could also "prove" that physicians play no role whatsoever in these increases. I could "prove" that Medicare and Medicaid have been the primary contributors to the increases in health care costs over the past 10 years. I could also "prove" they had a relatively insignificant part to play in that escalation. I could "prove" the whole country's going under if we don't get ourselves a national health insurance program, and soon. And, yes, I could also "prove" NHI's the last thing we need and would, in fact, have us bordering on the brink of bankruptcy very soon after it took effect.

In other words, I could "prove" just about anything I wanted to by strewing around *selected* statistics which, in and of themselves, would actually *prove* nothing. What's really frightening about all this is that it happens all the time. And you and I latch on to those statistics that appeal to us without really looking behind them, without really being informed, without really recognizing that in and of themselves they prove little or nothing. So I'm going to indulge in a little editorial freedom here and, in the body of this presentation, use statistics sparingly if at all.

What, then, does a bureaucrat write about if he can't strew out ominous statistics. Well, he can always prognosticate the future. That's pretty safe, because by the time the prognosticated events come (or do not come) to pass, few readers will remember what he said and practically none of those who remember will care. One in my position can't very well deal in "policy." I'm an administrative officer, not a policy officer. And I've said more than once (three times, in fact!) that in the government an administrative officer is to policy as a eunuch is to sex. (And that, I submit, ought to clarify that little detail!)

No, no stats, no policy. Just some thoughts developed over the past 4,213 days I've been involved (at this writing) in the Medicare program. None of that which follows is very profound, little of it is new, and much of it might not "set" very well, as we used to say down home in Savannah. But as Regional Medicare Director for the Southeast for 11 years, I've had an unusual vantage point from which to view the passing scene. A vantage point, you say, that would tend to give one a distorted or biased view of things? Perhaps. But consider as well my credentials as a "consumer" of health care (a rather tortured bit of terminology, yet I know of no better way to put it). Given the fact I've a wife who's had two heart attacks in the last 10 years plus other assorted ills, such as hypoglycemia, 11 hospitalizations in such diverse places as Atlanta and Johns Hopkins in Baltimore, with the accompanying expenses of insurance, costs above insurance, drug bills equaling if not exceeding physicians' costs — given all that, plus my own past middle-age physiological creakings, groanings, and deteriorations, you surely would agree the view isn't really all that slanted.

". . . the average practicing physician doesn't know what the hell is happening to him."

Speaking to the Florida Society of Internal Medicine during its annual meeting, I expressed one thought that quickly captured the wandering attention of that august group. I said to them (and I say it now to you, because I remain convinced of it to this day) that after working and being subject to the ministrations of physicians over the years, I really believe the average practicing physician doesn't know what the hell is hap-

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Mr. Richard is Regional Medicare Director, Bureau of Health Insurance, Health Care Financing Administration, U.S. Department of HEW, 50 7th St., NE, Atlanta, Ga. 30323.

pening to him. I further said that if he doesn't begin to learn what's happening, if he doesn't begin to become involved in *causing* things to happen, he's going to look around one bright and shiny day and discover — to his great surprise and utter horror — that the practice of medicine is no longer what it was (and what he wanted it always to be).

Oh, I'm not talking to those of you who are really involved in organized medicine, who are society officers, convention delegates, etc. I'm talking about the fellow who won't read his *Journal* because he's too busy, about the fellow who won't go to association or society meetings because they conflict in terms of time with hospital rounds, about the fellow who doesn't know (and one wonders whether he would care if he did know) that there are hundreds upon hundreds of bills affecting his vocation and the way he practices that vocation submitted to the Congress each year. I repeat: I'm thoroughly convinced that poor guy doesn't know what the hell is happening to him. And that's sad. It's sad, too, that I read these journals much more thoroughly than do most physicians. It's sad, too, that in one city where there are about 3,700 physicians, the medical association can't muster a quorum at meeting after meeting. No, the poor guy doesn't know what's happening.

"If we really want to do something about health costs, we need to face up to a few things."

What has all this to do with the broad subject of health costs or health financing . . . A great deal, I submit.

Where there is a void, it will be filled. And in the absence of action by the private sector, it will be filled by the government. There was a void, and we got Social Security. There was a void, and we got Medicare. There were voids, and we got Professional Standards Review Organizations, Health Systems Agencies, Program Review Teams, and a myriad of other governmental agencies and actions bearing on the health scene, on health care costs, among other things.

I'm not suggesting these things are bad, mind you. By the same token, I'm not suggesting they're good. I'm an administrative officer — remember the eunuch? What I *am* suggesting, though, is that each of these actions by the government would have been far better both conceptually and in terms of implementation, had there been involvement to a much greater degree of practicing physicians — the people who really know with a real degree of certainty what it takes to render good health care and, conversely, what it doesn't take to do so. Had there been greater broad-scale involvement of practicing physicians in peer medical utilization (not fee) review, PSRO probably wouldn't ever have come ambling down the legislative pike.

Health Systems Agencies would still be a figment of someone's imagination had there been forceful, meaningful involvement of practicing physicians in local and area health planning.

And that all leads to another thought. If we really want to do something about health costs, we need to face up to a few things. Despite the pummeling physicians have received in recent years about costs, it's a fact that hospital costs in this country are approximately twice as large as physician costs. I don't know what percentage of hospital costs go for personnel, but it's large, and it'll get larger. And there's nothing much we can hope to do about that. (As the husband of a registered nurse who served in hospitals for years, I've never really understood the logic that apparently assumes hospital personnel can buy groceries at the A&P on their good looks and therefore don't need wages equivalent to those of people in other professions.)

No, we can't do much about that, but something can and *must* be done about the *proliferation* of highly technical, extremely sophisticated, horribly expensive new equipment. CAT scanners come to mind. At $450,000 to $700,000 per scanner — those are very round figures — how much does a hospital add to each patient's cost per day when it purchases one? East now — I'm not suggesting that CAT scanners aren't just great, even though there still seems to be some division of opinion in the medical community about that. I'm simply suggesting that heavy physician involvement in the determination of need (as a compared to prestigious desirability) of such items in a given hospital is badly, badly needed. You wonder if physicians can do anything about this? One small example: When an established, recognized and effective planning agency refuses, in effect, to permit hospital "X" to purchase a CAT scanner as unneeded, is the medical community serving the total community when physicians then band together to purchase one and set it up in the professional building next door to the hospital? I think not. Whatever became of peer pressure?

" . . . the average physician . . . isn't involved . . . isn't influential . . . and doesn't play the role he should and must in . . . health activities of this country."

One could go on, but space doesn't permit. To sum up, it's my firm belief that because the average practicing physician doesn't know what the hell is happening to him, he isn't involved, he isn't influential, and he doesn't play the role he should and must in the overall health activities of this country. And because he doesn't, because he sits figuratively contemplating his navel while the whole scene changes around him, everything and everybody suffers, costs continue to shoot up, and the government of necessity continues to fill the void. And that's sad, because it doesn't have to be that way.

One final thought: I believe we've made it to this point without the use of statistical charts and columns of figures. Any time a bureaucrat can do that, there must be some hope for us left!

Health care delivery as seen by a Ford Motor Company exec:

Among the most pointed remarks made at the recent MSMS public affairs conference in Ann Arbor were those delivered by Jack K. Shelton, manager, Employee Insurance Department, Ford Motor Company. Mr. Shelton described his company's experience with greater use and cost of medical services in Michigan compared to the 17 other states in which Ford has plants, and offered his company's views on health care delivery. His comments are excerpted here.

• Between 1965 and 1977, Ford's health care bill increased from $68 million to about $450 million — or, to look at it another way, from an annual cost averaging $450 per active employee to nearly $2,000. We are forecasting 1978 costs at over $500 million.

There are many reasons for the dramatic cost increases which Ford has experienced including new benefits and an increased number of covered individuals, but the point which must be emphasized is that *over two-thirds* of the increase since 1965 was due to inflation and higher utilization.

• The costs previously quoted are for Ford US. An analysis of Michigan data indicates more serious concerns.

Michigan hospital costs per contract rank second highest of 18 plans and Michigan professional (or physician) costs are the highest of our 10 major plans.

Because 50 percent of Ford's health care costs are incurred right here in Michigan, state trends in health care costs impact significantly on total company costs. For example, if hospital and physician payments per contract for Michigan workers in 1976 could have been contained to just the *average* experienced in all other states, company costs would have been reduced by almost $33 million — a savings of 15 percent over the *total* hospital and physician cost of all US employees or an average savings of over $10 per vehicle (Ford produced).

• I, for one, do not believe that additional federal controls will be effective at containing costs. The answer has to be found at the local and state level through better health planning, the development of effective cost containment initiatives by health professionals, and the organization of alternative delivery systems which compete on the basis of service quality and cost.

• As physicians you cannot afford to put off recognizing that health care cost containment is your problem, that you — and you alone — hold the best key to its solution, and it will divert your attention and scarce resources from other serious medical problems until effective answers are found.

The impact of physician decisions on the cost of medical care is only now being documented. Physicians, as purchasing agents for patients, direct the utilization of hospital services, drugs, office visits, and other services. Although physician earnings account for only 14 percent of all personal health care expenditures — this represents 6.8 times the physician's own net income. Clearly, society's success at controlling health service utilization and cost is dependent upon the behavior of the key decision maker — the physician.

It would be a mistake for the medical profession to underestimate the importance of success of these (nonphysician cost control) programs (overbedding laws, planning act, certificate of need, BCBSM prospective payment program). I would encourage you to continue — if not increase — your efforts at working with hospitals, third-party payers, and planning agencies on their effective implementation. They will not be successful without physician support, and if they fail, greater pressure will be exerted for increased regulation of you — the key decision maker.

• The lesson is clear. If physicians — as key decision makers — fail to respond to indirect controls, more direct controls may result. I don't think this is in your — or society's — best interest, and I would encourage you to aggressively design private sector solutions to these problems. Important first steps in this direction are the National Voluntary Cost Containment Effort and your discussions with the Michigan Blues regarding physician reimbursement. These discussions are being followed with great interest, and I am hopeful that, working together in the private sector, a new cost-effective physician reimbursement program will be designed.

I have identified two major areas which concern me as a prudent purchaser of health care services:

• 1. *The impact of physician supply on the cost of health care services.* There is a growing body of research indicating a negative relationship between physician density and workload, and a positive correlation between physician density and fees.

". . . Michigan professional (or physician) costs are the highest of our 10 major plans."

Put simply, data indicate that the greater supply of physicians, the higher the fees and the lower the average workload. Even more serious are studies indicating that increases in the number of physicians result in increases in the intensity of services and utilization.

Health economists estimate that each additional doctor entering the market creates from $150,000 to $350,000 in health care spending annually. With the number of doctors growing three times faster than the population, the cost implications of these statistics are frightening.

It's clear from these statistics that the traditional forces of supply and

(Continued on page 616)

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CEFAZOLIN SODIUM
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OF SERIOUS RESPIRATORY INFECTIONS

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported: Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. Blood: Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred. Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Gastrointestinal: Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported. Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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demand do not exist in the health system.

- The real challenge then to all of us — consumers, purchasers, planners, third-party payers, and doctors — is how market imperfections can be corrected and effective incentives created for lower utilization and less costly types of care without compromising quality. This will not be easy — and it deserves your priority attention.

Traditionally, when society faces an imperfect market it responds in one of two ways. Either it regulates the service or it attempts to restore competition. With few exceptions, government response in the health care area has been to regulate, and in the face of still rising health care costs, further regulation is being considered.

". . . your medical progress is being over-shadowed by the cost issue."

I would encourage the medical profession to decide which of the two alternatives it prefers — greater economic competition or increased regulation.

Personally, I would prefer greater economic competition and the delivery of care by the private sector. However, for this alternative to become viable, it must be embraced more favorably by the medical community.

In communities where the medical profession has accepted this challenge, the results have been encouraging.

- 2. *Excess utilization of health care services.* We believe that there is a significant amount of over-utilization of medical services, especially hospital services.

Our most serious concern is hospital utilization because of the enormous increases in hospital costs. I believe that utilization review should be extended beyond hospitalization to include all medical treatment through an approach such as model treatment screening. But because of the high cost of hospitalization — a national average of about $200 per day — I would like to focus on this area.

Frequency of hospitalization and utilization of services per hospitalization are variables directly within the individual physician's control.

We have been studying the hospital utilization data for our employee population and see dramatic variations in utilization patterns between areas of the country that suggest that there is substantial room for reductions in hospitalization.

As I just mentioned, our standard fee-for-service plan areas have hospitalization rates ranging from 1,259 to 754 patient days per 1,000 population. When I compare this rate with those experienced by the average pre-paid group practice plan in the US — about 450 days per 1,000 — I conclude that there must be considerable room for reducing the amount of hospitalization in the fee-for-service practice area.

- We believe that one reason for the high hospital utilization rates being experienced is unnecessary surgery. In fact, in many of our fee-for-service plan areas, the surgical admission rates alone exceed the group practice plan hospitalization rates for all causes. This fact, coupled with the results from some second-opinion programs indicating the need for surgery is not confirmed in about 25 percent of all elective cases leads us to believe that there is room to reduce the amount of surgery practiced in the US.

Data like this are very discomforting to a layperson. I realize this is a controversial area, and there is considerable difference of opinion about what constitutes medically necessary surgery. The second opinion studies and comparisons with group practice plans suggest to me that physicians can and must develop mechanisms for ensuring that all hospitalizations and surgery are predicated on sound medical need.

The over-utilization principle extends beyond hospitalization. I suspect that many tests and procedures are being ordered which cannot be justified based upon medical need. According to Michigan Blue Cross and Blue Shield, the volume of laboratory and pathology tests has increased 547 percent in just six years. As we saw earlier, the cost of laboratory and other diagnostic services per employee in Michigan was over four times the average cost being experienced by other states.

"What is needed is for you to lead the medical community into constructive cost containment efforts."

The ordering physician is the individual that makes these decisions, and it may be time to re-evaluate — or evaluate for the first time — the cost effectiveness of the tests and procedures ordered. Physicians and medical societies can attack these problem areas through the development of standards that are incorporated in meaningful and locally managed peer-review systems.

- The point I want to leave with you is not that I think there is nothing right with American medicine but that your medical progress is being over-shadowed by the cost issue. You should not underestimate the forces at work that demand near-term progress toward containing the cost problem. Hospitals and physicians will be subjected to increasing criticism and demands for action programs that counteract the health care cost spiral. I think you must avoid falling into a defensive posture in response to these pressures. That would be counter-productive. What is needed is for you to lead the medical community into constructive cost containment efforts. With your assistance, programs can be developed that are responsive to the real problems and yet compatible with the priorities and perspectives of your profession.

(More on page 621)

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100	Thorazine (50 mg.)	6.03	Chlorpromazine HCl (50 mg.)	**3.23**	**2.80**
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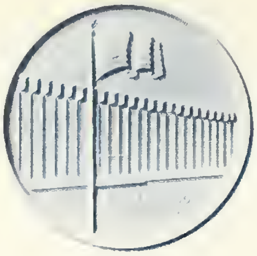

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(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly *Drug Dependence*. Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*. Tenuate is not recommended for use in children under 12 years of age
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses In a few epileptics an increase in convulsive episodes has been reported *Gastrointestinal*. Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H M. A Comprehensive Review of Diethylpropion Hydrochloride International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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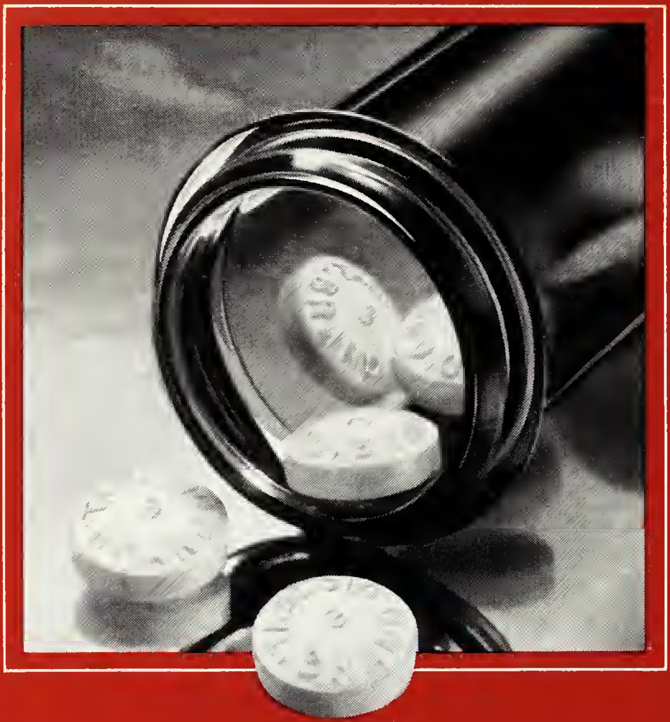

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Many family physicians dedicated to supporting metropolitan areas

By Archie Bedell, MD, PhD
Detroit

Relative to the recent publication in a major Detroit newspaper regarding the distribution of practitioners within the greater metropolitan area, I would like to express a few comments.

Thomas W. Tenbrunsel, PhD, associate professor of urban and metropolitan studies in the Michigan State University College of Urban Development, certainly has done a fine job in outlining a major problem in relationship to the acute shortage of general, and/or family practice type physicians in the urban area of Detroit.

His study related to practitioners in the city of Detroit, and I support his findings. However, I would like to add that at the present time we have seven major family practice residency programs in the greater metropolitan area which also includes the university-based program at Wayne State University School of Medicine. These programs are responsible for producing family practitioners for the underserviced area of Detroit, as well as more rural areas which may be devoid of primary care physicians.

I truly believe that the effort made on behalf of many of us as program directors to overcome this shortage, has been a major thrust to recognize the fact that there is a population based within the city limits of Detroit that is in dire need of medical care. Therefore, we stress training in areas of preventive medicine, community medicine, and certainly in behavioral sciences in our training programs, to enable each of our graduates to have a broad background in family medicine, as well as to prepare them for the type of interdisciplinary ethnic and racial conflicts that may occur, if confronted with practicing in an urban setting. The families contained within the greater metropolitan area of Detroit are in dire need of quality health care delivery by physicians who are dedicated to serve them.

There are hazards other than financial risk alone, namely violence. However, if one looks at the more recent statistics, one notes that the city has worked arduously to decrease that element of risk.

As far as the rapid exodus of physicians referred to by Doctor Tenbrunsel of MSU, there is no question that there is a higher turnover within the urban area of such practitioners.

Another issue which was avoided in his article is a real threat, namely the incidence of malpractice suits within the urban setting. This incidence definitely is higher there. This last year one notes a decline in suits, but only time will determine whether or not this has become a real trend.

Finally, it is easy to understand that many young people entering the practice of medicine are desirous of living in an area that is warm, clean, safe and contains a structured social forum, as well as educational services which are above and beyond question. Detroit fails to deliver the former, but is working toward the latter.

Therefore, the new family practitioner within the greater metropolitan area has at his or her feet, an urban population of great magnitude, with low competition, some degree of personal risk, one that may not have the educational or theatrical advances of other major cities, but certainly has a potential if supported.

The patients are here in the urban area. The need is here. The training centers are available to provide the types of people to lead such an endeavor.

But I must ask the question: Is the personal commitment to be self-sacrificing and unselfish enough to become a frontiersman in a jungle of humanity lacking total structure and direction? To promise is one thing, but to do is another. Our commitment to support the urban centers must be most firm and substantiated by individual self sacrifice by us.

Doctor Bedell is director, Family Practice Residency Program, Bon Secours Hospital, Grosse Pointe.

What were the recent claims about too few Detroit physicians?

There is an acute shortage of general practice physicians in the city of Detroit, according to a Michigan State University study of doctor mobility.

Thomas W. Tenbrunsel, PhD, associate professor of urban and metropolitan studies in the MSU College of Urban Development, and research associate William P. Segodnia gathered data on all physicians who practiced medicine between 1965 and 1977 in Detroit, Hamtramck and Highland Park.

They reported physicians are attracted to Detroit in substantial numbers, but don't stay there very long. According to their findings, the rate of departure within four years of entering the city was 30 percent for physicians who entered Detroit prior to 1965. Between 1969 and 1973 the rate of departure had increased to 59 percent within four years.

Of those MDs practicing in Detroit in 1965, only 36.5 percent were still in practice there in 1977, the study showed. In addition, the researchers found that general practitioners, who accounted for 21 percent of Detroit MDs in 1965, made up only 12.8 percent of all physicians in 1977, well below the national average.

This means there is an ample supply of MDs in institutional settings such as hospitals, clinics and health maintenance organizations, they said. However, "Consumers demanding private office-based care are presently experiencing a shortage of available physicians."

MDs must use initiative to assure all children immunized

By John L. Isbister, MD
Lansing

Every week since January, Michigan has had the unfortunate distinction of leading the nation in reported cases of measles, rubella and mumps. While rubella outbreaks have been concentrated in Bay, Midland, Oakland, Macomb and Wayne Counties, principally, virtually no county has been spared. High school and college age groups have been primarily involved.

The measles outbreaks have been more widely distributed both geographically and demographically. Counties contiguous with Washtenaw were the first to report large outbreaks but eventually all of the major metropolitan areas were involved. Flint and Lansing have been especially hard hit. Typically, the pattern of measles spread has been from older to younger students. Outbreaks have spread between college campuses from university populations to local high schools, down to middle and elementary school grades and eventually to some preschoolers.

From January 1 through August 4, reported morbidity totals 6,758 for measles, 2,960 for rubella, 1,336 for mumps and there were 18 cases of pertussis. In this epidemic year, 80 percent of the measles cases occurred in the 8-20 year group and 75 percent of the rubella cases in the 13-20 year group. The peak incidence for measles was 13 years and for rubella it was 16 years.

Immunizations slipping backwards

The occurrence of so many cases of easily preventable communicable diseases points out a flaw in the Michigan health care system which otherwise has so many stars in its crown. At a time when the interest of the nation has been turned to the goal of complete control of immunizable diseases, we find ourselves slipping backwards. The sad part of it is that we have a good health care system and the tools to get this job done.

Our primary need is to identify those children in our communities who need immunizations and get the antigens into them. Although estimates can be misleading, sampling done by the Michigan Department of Public Health indicates that, of Michigan's 3,169,658 children from ages less than one to 18 years, immunization efficiencies are 532,376 for measles, 293,127 for rubella, 585,000 for mumps, 474,600 for DTP and a very alarming 977,153 for polio.

It must be noted that, for the respective diseases, these figures do not necessarily mean complete susceptibility; rather, they indicate that these numbers of children lacked the full series of immunizations in total or in part for the identified disease.

The sampling which provided these figures also indicated that private physicians provide immunizations to 66.2 percent of two-year olds and 25 percent of the school age group. Public health clinics immunized 29.5 percent of the two-year olds and 40 percent of the school age group. It could not be determined how 4.3 percent of the two-year olds and 35 percent of the school age group had been immunized.

How to improve?

What can be done to improve our position in the nation with respect to vaccine-preventable diseases?

1. *Enforce school entry immunization laws:* The passage this year of the Public Health Code can signal a new era in this struggle. Section 92 states that children must be immunized to enter school and is fairly specific in saying that children lacking an immunization record, statements of medical contra-indications or signed parent waivers must be excluded from school. It was found last year that this process did not hurt too much when Detroit applied it under Section 376 of the School Code. Under the law, the minimum immunization requirements for first day school attendance are one DPT, one polio, one measles and one rubella shot. By January, all students must have at least three DPTs and three polio doses.

2. *Assess immunization levels in grades one through 12:* Our recent outbreaks have indicated there are a great many kids in the upper grades lacking some immunizations. If we are going to stay ahead of the next epidemic, it is essential we identify these kids and make up the deficiencies. Livingston County already has begun a systematic record search of all grades and the early results are shocking. Only two children in one high school class of over 400 were completely immunized. On the average, three-fourths of the students lacked proof of one or more immunizations. Second grade students reported as unimmunized two years ago are still unimmunized despite the presence of a school nurse. Certainly, Livingston County is not an exception.

3. *Apply prompt and effective outbreak control measures:* This requires that, when an outbreak occurs in a school, there must be an immediate response.

- There must be prompt reporting by the schools of the occurrence of the disease in their areas.
- Once case history reports confirm the diagnosis, the susceptibles in the schools must be identified.
- Susceptibles must be brought to immune status with the appropriate antigen through their private physicians or public health clinics and this opportunity should be used to update all possible vaccine deficiencies.

The acute communicable diseases of childhood will continue to be with us. It is doubtful if any of them can be eliminated as has smallpox. Generally, they are all vaccine-preventable and whether or not they continue to exert their adverse influence will depend on our initiative in applying the tools we have available for prevention.

Doctor Isbister is Disease Control Officer, Michigan Department of Public Health.

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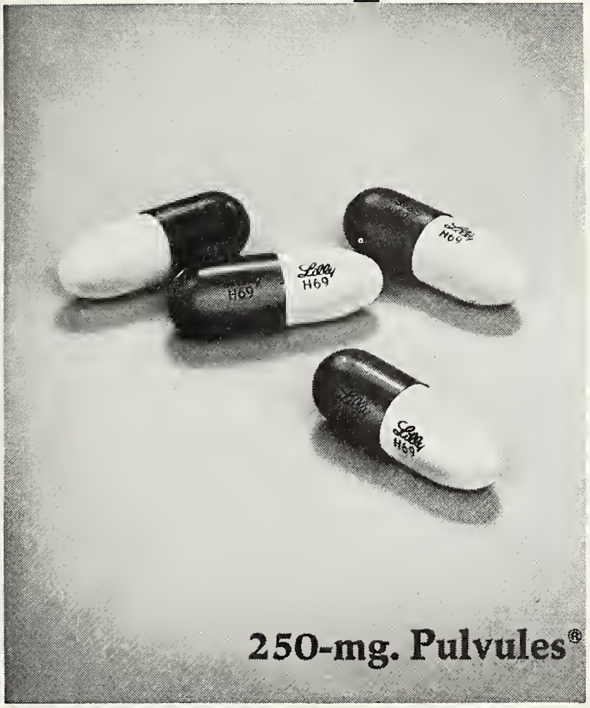

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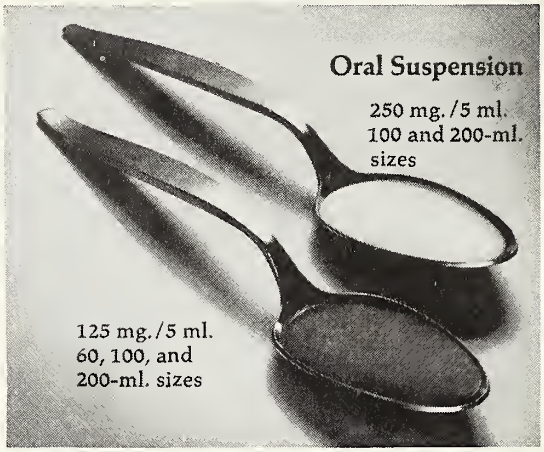

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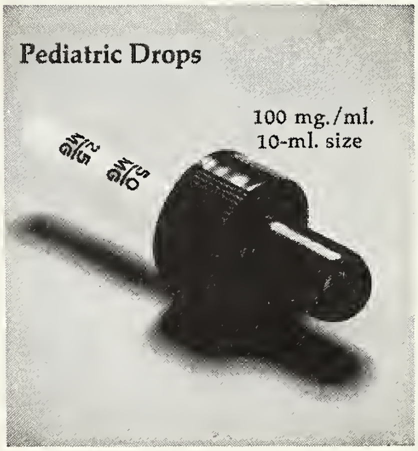

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MPMLC Clipsheet

This is the first in a series of articles intended to better inform Michigan physicians about the Michigan Physicians Mutual Liability Company and its activities. Inquiries may be directed to MPMLC at P.O. Box 1471, East Lansing, 48823; phone 800/292-1460 (toll free) or 517/351-1150.

History

MPMLC was established in 1975 upon recommendation of the MSMS Task Force to Consider a Self-Insured Professional Liability Program. Following nearly a year of fund-raising effort, the company achieved capitalization sufficient to begin writing coverage on May 12, 1976.

By the end of September, 1978, the company insured approximately 2,500 physicians and surplus certificate sales had exceeded $7,000,000.

Philosophy

MPMLC was founded to provide a source of professional liability insurance to all Michigan physicians who merit coverage. The company philosophy of physician control and peer review is reflected in the board of directors, underwriting committee, and claims committee, which are comprised of physicians. As members of a mutual insurance company, MPMLC insureds will benefit from company earnings.

Management

The Stratton-Cheeseman Management conducts MPMLC's daily operations, including application processing, claims management, and corporate investments. The management company's staff of insurance experts coordinates underwriting, claims, and investment activities with corresponding MPMLC Committees.

1978 rate change yields more equitable premiums

A 1978 rate level 2.2 percent lower than the company's original rates is the result of a major actuarial study commissioned by MPMLC in 1977. The more accurate loss projections of the study also have made possible a significantly more equitable premium structure.

The 1978 rate level is based on loss experience incurred by other Michigan medical professional liability insurance companies in the years 1970 to 1974. The actual premium differences (relativities or differentials) among the rating classes rely on national loss experience for the same years. This use of national loss experience was necessary to meet statistical credibility requirements of the Michigan Insurance Bureau.

Because the actuarial study indicated a realignment of premiums as well as a decrease in rates, no premium actually dropped by 2.2 percent. In fact, premium changes ranged from a decrease of 71 percent for proctologists to an increase of about 50 percent for Class 2 physicians.

The rate re-evaluation study was, in part, a response to concerns of several segments of the physician community that some physicians were subsidizing others by paying higher premiums than statistics would indicate for their specialty or location.

MPMLC's original rates were derived from rates of physician-owned companies in other states, analysis of competitors' rates, and judgement of the company's consultants. Those proposed rates were then increased by a percentage prescribed by the Michigan Insurance Commissioner. Given the unstable medical professional liability insurance climate at the time, this process was considered a valid method of determining initial rates.

A major priority of MPMLC continues to be the reduction of rates. As more and better statistics become available, the company intends to make every reasonable effort to offer rate decreases in the future.

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Here's how Board of Medicine carries out disciplinary actions

By Charles Downs
Special to **Michigan Medicine**

(This is the second of a three-part series examining the role of the Board of Medicine and its relevance to all Michigan physicians.)

In 1977, the Michigan Board of Medicine limited the licenses of four physicians, revoked the licenses of three, suspended four, put one doctor on probation, reprimanded three others and saw seven forfeit or surrender their licenses.

These numbers are relatively small in contrast to the 351 doctors whose licenses were terminated by the board because they did not meet continuing education requirements (many were retiring).

Nevertheless, the disciplinary actions are perhaps the main reason for the board's existence and at the same time the chief reason for criticisms and sometimes, outright hostility on the part of many Michigan physicians.

Such criticisms are usually based on lack of understanding, says John R. Wilson, MD, president of the board. Noting that 10 of the 13 members of the board are practicing physicians themselves, he contends that no physician is charged without ample evidence of state law violation and no one is found guilty without due process that protects the individual's rights and privileges.

How action begins

The board initiates actions against physicians on the basis of (1) complaints, (2) disciplinary actions taken by hospitals against staff members, and (3) reports from the insurance commission regarding malpractice suits.

Many complaints — 122 out of 259 last year — are quickly dismissed because there is no apparent legal violation or because the board lacks jurisdiction.

"Complaints often have nothing to do with the Medical Practice Act," says Doctor Wilson.

"For example, a frequent complaint is overcharging, but unless there appears to be a case of fraud, fees are not covered by the law."

"Also, patients sometimes complain that they just don't like a certain doctor or that he was nasty to someone or that he didn't cure a son or a daughter. One person alone has made many such complaints against physicians on the staffs of some of the state's finest medical centers."

Complaints drug-related

On the more serious side, however, are the complaints that are drug-related — 61 of them in 1977. Many of these stem from work of the Diversion Investigative Unit (DIU), part of the Division of Regulation and Licensing (DLR). The DIU, which is staffed by experienced narcotics investigators, receives information from police, people on the streets, pharmacists and other sources about illegal diversion of prescription drugs.

Still another area of serious concern and the one that most often results in formal changes is the "sick doctor" — physicians who, because of mental or physical illness, senility, alcoholism or other drug abuse, are no longer effective practitioners.

Reviews of hospital disciplinary actions and reports of malpractice suits by the DLR's Medical Science Unit turn up relatively few cases of law violations. There were 510 such hospital actions and 1,667 malpractice reports in 1977 but at the end of the year, only 46 of these cases were being investigated for apparent violation of the Medical Practice Act.

When there is a strong evidence of the violation of law, the first step taken is the issuance by the board of a formal complaint. This leads to a compliance conference. This is a closed hearing attended by staff, the charged physician and his attorney, an assistant attorney general, and, usually, a member of the board.

The purpose of such conferences is to explore the charges and to try to reach agreement on disposition. The conferences are informal and no written record is kept.

In about five percent of the cases, agreement is reached and no further action is necessary. If not, the participating board member has nothing further to do with the case. He may not discuss it with other members; nor may he vote on it.

Formal learning next

The next step is a formal hearing before an officer appointed from the DLR staff. Again, the physician is represented by counsel and the state by an assistant attorney general. Also, a board member is usually present. This hearing is formal, public and on the record.

A complete transcript of the hearing is sent to each member of the board for review. Then, at its next meeting, the board renders a judgment on the case.

If the charged physician does not wish to accept the judgment, he may take it to a circuit court and from there to an appeals court. The majority of cases are taken to court even though the courts generally uphold the board's action.

Despite frustrations such as legal delays, Doctor Wilson believes that the board and its staff are doing a good job. Their objectives and methods are frequently misunderstood, however, he says.

"We must do more than be advocates of the physician," he says of himself and other practicing physicians on the board. "We also must be advocates of the patient, no less than we are in our respective practices."

(Next Month: Developing standards of minimal medical care, the hardest and potentially the most rewarding challenge facing the board.)

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Meetings

Calendar for AMA, MSMS, Auxiliary and Medical Assistants

Nov. 30-Dec. 1 — Seminar for CME program planners and instructors, MSMS headquarters, contact: Katie Brewbaker, MSMS headquarters.

Dec. 2-6 — AMA House of Delegates Interim Meeting, Chicago.

Dec. 7 — AMA Winter Scientific Meeting, Las Vegas.

Dec. 13 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 24 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Feb. 3-4 — Medical Assistants Mid-winter Seminar, Jackson, contact: Helen Schulte, MSMS headquarters.

March 4 – Medical Assistant Board Meeting, MSMS headquarters, contact: Helen Schulte, MSMS headquarters.

March 7 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

April 10 — Legislative Day, MSMS Auxiliary, Olds Plaza Hotel, Lansing, contact: Helen Schulte, MSMS headquarters.

April 26-29 — Medical Assistants State Convention, Lansing, contact: Helen Schulte, MSMS headquarters.

May 4-6 – MSMS Auxiliary Annual Convention, Kalamazoo, contact: Helen Schulte, MSMS headquarters.

May 4-5-6 — MSMS House of Delegates, Kalamazoo Center Inn, Kalamazoo, contact: Richard Campau, MSMS headquarters.

MSMS headquarters used often by many groups

October Meetings **(held in the MSMS headquarters unless specified otherwise).**

PSRO Region VI Data Managers
Ingham County Medical Society Executive Committee
Liaison Committee with Medical Practice Board, University Club, E. Lansing
PSRO Region VI Personnel Committee
Committee on CME Accreditation
Ingham County Medical Assistants
Finance Committee
Physician Liaison Committee
Liaison Committee with MSMS Work Group, University Club, E. Lansing
PSRO Region VI
Council of Specialty Societies
Planning Committee for 1979 Maternal and Perinatal Health Conference, Howell
Committee on State Legislation and Regulations
Committee on Public Service

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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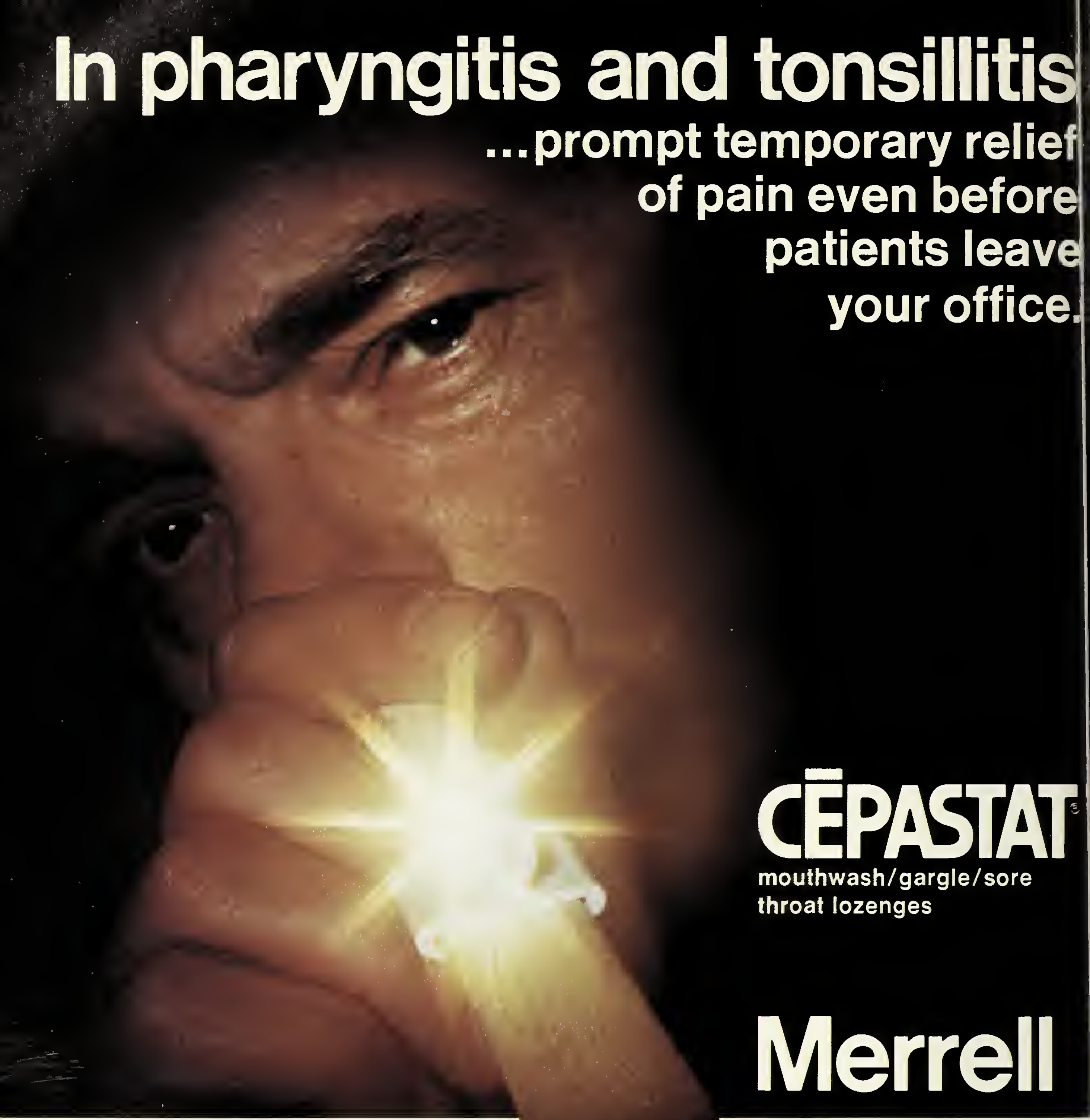
*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.



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B-3983 (Y572A)

News

By Katie Brewbaker, MSMS staff

Ingham Medical Center, Lansing, has named its new pediatric intensive care unit in honor of **Gerald A. Zick, MD.** Doctor Zick has served as medical staff chairman for the Center's pediatric department during the five years the unit was being planned.

The old Federal Building in Pontiac is sporting a new name and providing a new service to the community. The downtown structure is now a community arts and recreation center and is called The Furlong Building, in honor of **Harold A. Furlong, MD,** a long-time benefactor of the arts. Doctor Furlong is founder and president of the Pontiac Creative Arts Center and has been one of its principle fundraisers.

Austin A. Aardema, MD, of Muskegon, is a member of the newly appointed AMA Ad Hoc Task Force on Juvenile Treatment. The Task Force, named by the AMA Board of Trustees in June, is one of three task forces charged with the responsibility of developing further guidelines for the accreditation program under the AMA's jail health project.

Chairman of the AMA's Ad Hoc Committee for Foreign Medical Graduate Affairs is **Mohammad N. Akhter, MD,** of Lansing. In addition, Doctor Akhter has been named president-elect of the American College of International Physicians, Inc.

Daniel S. Mazzuchi, MD, Marquette, is new vice president of the Upper Peninsula Health Education Corporation. The corporation, in cooperation with the MSU College of Human Medicine, administers the UP Medical Education Program which is designed to increase the number and distribution of primary care physicians in underserved areas. Doctor Mazzuchi is an assistant professor in the MSU Departments of Medicine and Family Practice.

The medical director of the Cass County Health Department, **James M. Davis, MD,** is recipient of the 1978 Michigan Health Officers Association Distinguished Service Award. Doctor Davis was cited for "an outstanding contribution through service in public health to the county, region, district or state office to which assigned." In addition to his award, Doctor Davis was further honored by being elected president of the Michigan Health Officers Association for the coming year.

Thomas A. Tenaglia, MD, Lincoln Park, is this year's recipient of the Michigan Academy of Family Physicians' "Family Physician of the Year" award. The award is presented annually to the family physician who best epitomizes the ideals and qualities of family practice.

James T. Harrison, MD, Gaylord, has been appointed Regional Medical Director by the boards of health for District Health Departments Three and Four. Doctor Harrison will be in charge of the health departments serving Alpena, Antrim, Charlevoix, Cheboygan, Emmet, Montmorency, Otsego, and Preque Isle counties.

The U-M Regents have announced the appointment of **Robert E. Reed, MD,** as associate dean of the U-M Medical School. Doctor Reed, who has served as associate professor of internal medicine and director of the Inteflex program, assumes his new post immediately.

Israel Fradkin, MD, has joined the Upper Peninsula Medical Education Program (UPMEP) to serve as director of family practice residency and associate professor of medicine for the MSU College of Human Medicine. The family practice residency, scheduled to begin training physicians in July 1979, is sponsored by Upper Peninsula Health Education Corporation, with assistance from a W. K. Kellogg Foundation grant. The residency is affiliated with Marquette General Hospital and MSU College of Human Medicine.

Harvey V. Sparks, Jr., MD, will assume duties as chairman of the MSU Department of Physiology December 1. The physiology department, in addition to serving the colleges of human medicine and osteopathic medicine, serves the colleges of veterinary medicine and natural science. Doctor Sparks comes to MSU from the University of Michigan where he has been a member of the physiology faculty since 1966.

David W. Bailey, MD, is new associate chief of pediatrics at Children's Hospital of Michigan in the Detroit Medical Center. Doctor Bailey, former chairman of pediatrics at the National Naval Medical Center in Bethesda, will be in charge of recruitment, planning and operation of the residency program at Children's.

If you happen to notice two rather unique students standing in line to enroll in college at Kalamazoo, it may well be **Doctor John R. Rodger** and his wife **Katherine.** What might make them stand out among the panoply of other students is that Doctor Rodger is silver haired and 73 (good taste does not permit us to mention Mrs. Rodger's age). After 43 years of serving the medical needs of his patients in the Bellaire area, Doctor Rodger has retired and plans to move to Kalamazoo where he and Mrs. Rodger will enroll as part-time students. But, not before their many friends have a chance to express their thanks at a special banquet in their honor at Shanty Creek. Doctor Rodger is not only well-known, and appreciated, by the citizens in his community. For many years he chaired the MSMS committee on Highway Injury, served as a member of the AMA committee on highway safety, and in 1967 was one of 10 persons named by then Governor George Romney as "Citizens of the Year."

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

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Category I courses

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Nov. 15-16, Mammography for Radiologic Technologists. Location: Towsley Center for CME, Ann Arobr. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the U of M Medical School. **For:** Radiologic Technologists. **Cost:** $80. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 14 hours of Category I Credit.

Date: Nov. 16, The High Risk Neonate: A Symposium on Birth Defects. Location: Mercy College, Detroit. **Sponsor:** Metropolitan Detroit March of Dimes Health Professional Advisory Committee, Wayne County Medical Society and Wayne State University College of Nursing/College of Life Long Learning. **Cost:** $30. **Contact:** Joan Leavy, 313/864-6000. **Approved for:** 8 hours of Category I Credit.

Date: Nov. 17-18, Otorhinolaryngology Conference. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, U of M Medical School. **For:** Otolaryngologists. **Cost:** $120. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 12 hours of Category I Credit.

Date: Nov. 17-18, Medical-Surgical Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians, surgeons. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: Nov. 21, Leukemia and Lymphoma Symposium. Location: St. Mary's Hospital, Xavier Hall, 200 Jefferson, SE, Grand Rapids. **Sponsor:** Grand Rapids Clinical Oncology Program. **For:** All specialties. **Cost:** $30. **Contact:** Grand Rapids Clinical Oncology Program. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 28-30, Diagnosis and Treatment of Arrhythmias. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the U of M Medical School. **For:** Internists. **Cost:** $180. **Contact:** Office of Continuing Education, U of M Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 21 hours of Category I Credit.

Date: Nov. 29, Thyroid Disease Diagnosis/Management. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** Department of Family Practice, MAFP. **For:** Family practitioners, internists, surgeons. **Cost:** $15. **Contact:** Jean Machtel, CME Coordinator, 517/487-2790. **Approved for:** 5 hours of Category I Credit.

Date: Nov. 30-Dec. 1, Seminar for CME Program Planners and Instructors. Location: Michigan State Medical Society, East Lansing. **Sponsor:** Michigan State Medical Society. **For:** All specialties. **Cost:** $35. **Contact:** Katie Brewbaker, MSMS, Box 950, East Lansing 48823. **Approved for:** 9 hours of Category I Credit.

Date: Dec. 2, Chronic Illness and the Family. Location: Ramada Inn, Telegraph Road at 11 Mile, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Cost:** $20. **Contact:** Family Institute of Southeastern Michigan, 17352 W. 12 Mile Rd., Ste. 100, Southfield, 48076, 313/559-2440. **Approved for:** 3 hours of Category I Credit.

Date: Dec. 2, Nutrition and the Hospitalized Patient. Location: Hurley Medical Center, Flint. **Sponsor:** Hurley Medical Center Nutrition Support Team, Dept. of Continuing Medical Education and Norwick-Eaton Pharmaceuticals. **Contact:** Richard D. Garlick, director of continuing medical education, Hurley Medical Center, 6th Ave. & Begole, Flint, 48502, 313/766-0142. **Approved for:** 6 hours of Category I Credit.

Date: Dec. 5, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Dec. 9, December Seminar. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit or James W. Landers, MD, Department of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 18-20, Rheumatology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Rheumatologists, internists, family physicians. **Cost:** $150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: Jane. 24, Lymphoma Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Jan. 28-Feb. 2, Fourth Annual Seminar, "Emergencies in Medicine." Location: Boyne Highlands, Harbor Springs. **Sponsor:** Michigan Committee on Trauma, Michigan Society of Critical Care Medicine. **Cost:** $40. **Contact:** Robert F. Wilson, MD, or Theresa Sokol, WSU, Dept. of Surgery, School of Medicine, 540 East Canfield Ave., Detroit, 48201. **Approved for:** 23 hours of Category I Credit.

Michigan physicians may write MSMS, 120 W. Saginaw St., East Lansing, 48823 for meetings of later dates.

Date: Feb. 4-9, Family Practice Update. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $200. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: Feb. 10, Hematopathology. Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 15, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 19-23, Emergency Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians, internists, emergency physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 35 hours of Category I Credit.

Date: Feb. 27-28, Psychophysiologic Illness. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, primary care physicians. **Cost:** $100. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Feb. 28-March 1, Michigan Conference on Maternal and Perinatal Health. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Herb Auer, MSMS, 517/337-1351. **Approved for:** 14 hours of Category I Credit.

Date: March 6-9, Hematology Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Hematologists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: March 14, Kidney Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: March 14-16, Advances in Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Of-

(Continued on page 638)

NUTRITION AND THE HOSPITALIZED PATIENT

John W. Broviac, M.D.
E. W. Sparrow Hospital
Lansing, Michigan
Asst. Prof. of Medicine
Michigan State University
East Lansing, Michigan

Alexander E. Nehme, M.D.
Educational Chief of Surgery
Hurley Medical Center
Flint, Michigan
Asst. Prof. of Surgery
Michigan State University
East Lansing, Michigan

Mitchell V. Kaminski, Jr., M.D.
Clinical Prof. of Surgery
University of Health Sciences
Chicago Medical School
Director
Midwest Nutrition Education
and Research Foundation
St. Mary of Nazareth Hospital Center
Chicago, Illinois

Anne L. Winborn, R.D.
Research Dietitian
Metabolic Support Service
St. Mary of Nazareth Hospital Center

NUTRITION SUPPORT TEAM

Judene Bartley, M.P.H.
Charlotte Gibson, R.D.
Sherry Goodfellow, M.S., R.D.
Connie Hagelshaw, M.S., R.D.
Walter Hickey, R.Ph.

Hope McCracken, R.Ph.
Denise Rumsey, R.D.
Hurley Medical Center
Flint, Michigan

Saturday, December 2, 1978 – 9:00 a.m. - 3:45 p.m.

Approved for Six Category I hours

For further information call or write: **Richard D. Garlick**
Director of Continuing Medical Education – **Hurley Medical Center**
Sixth Avenue and Begole Street – Flint, Michigan 48502 (313) 766-0142

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CATEGORY I/*Continued*

fice of Continuing education, Dept. of PGM/HPE. **For:** Pediatricians. **Cost:** $160. **Contact:** Towsley Center for CME, 313-764-2287. **Approved for:** 21 hours of Category I Credit.

Date: March 21, Early Breast Cancer. Location: Kalamazoo Center Inn, Kalamazoo. **Sponsor:** Bronson and Borgess Hospitals Oncology Section. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All Interested Physicians. **Cost** $50. **Contact:** Leo Zelkowitz, MD, Bronson Hospital, 252 East Lovell, Kalamazoo, 49007. **Approved For:** 7 hours of Category I Credit.

Date: March 24, A **Day of Clinical Gastroenterology. Location:** Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **For:** Family physicians, internists. **Cost:** $70. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: April 12, Conference on Medical Aspects of Sports. Location: Towsley Center, Ann Arbor. **Sponsor:** MSMS. **Contact:** Herb Auer, MSMS, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 16-20, Family Practice Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: April 24, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $20. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: May 10-11, Ophthalmology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 12 hours of Category I Credit.

Date: May 14-18, Head and Neck Oncology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otorhinolaryngologists, surgeons. **Cost:** $500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

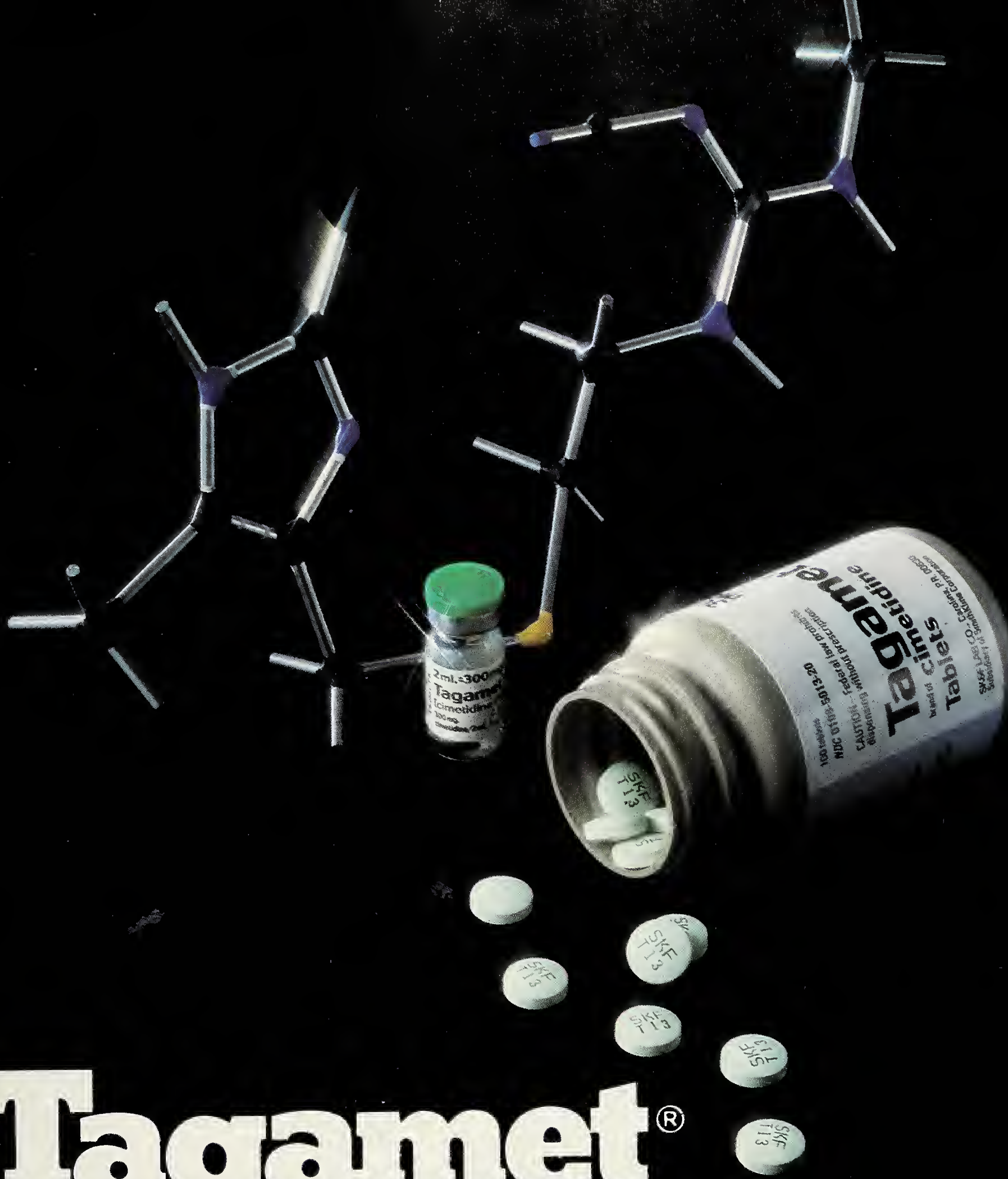
Date: May 21-25, Advances in Internal Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Internists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: June 7-8, Blood Banking. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $90. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

The MSMS Committee for CME Programming has agreed to co-sponsor the following events. MSMS members will be permitted to attend, provided they pay any tuition charges, meal costs, etc.

Date: November 16. "Symposium on Birth Defects: Problems of the Neonate" — a program presented by the Wayne County Medical Society, Metropolitan Detroit March of Dimes Health Professional Advisory Committee, and Wayne State University College of Nursing — co-sponsored by the MSMS Committee for CME Programming — at Mercy College, Detroit. Seven hours of Category I credit. For details write Isabel Markham, Symposium Coordinator, Metropolitan Detroit March of Dimes, 20100 Greenfield, Detroit 48235.

Date: January 10. "Chronic Rhinitis" — a program presented by the Michigan Allergy Society — co-sponsored by the MSMS Committee for CME Programming — at Mercy College Convention Center, Detroit. One hour of Category I credit. For details write Clyde R. Flory, MD, 201 W. Hillsdale, Lansing 48933.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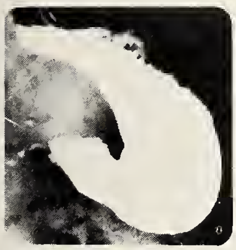
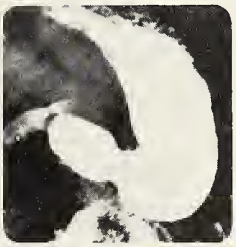
. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders), and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful Bentyl may produce drowsiness or blurred vision In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with autonomic neuropathy, hepatic or renal disease, ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon, hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension, hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis) Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response The physician must delineate these Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste; headache, nervousness, drowsiness, weakness; dizziness, insomnia, nausea; vomiting; impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs
Usual Dosage Bentyl 10 mg capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water) Bentyl 20 mg *Adults* 1 tablet three or four times daily Bentyl Injection *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
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Disciplinary Actions of the Michigan Board of Medicine Aug. 3, 1978 Meeting

The following actions of the Michigan Medical Practice Board are taken from an official memorandum to MSMS and are not editorialized:

Charles H. McManus, MD, Traverse City. License suspended for sixty (60) days effective thirty (30) days after 8/14/78.

Kwoh Cheng Sun, MD, Addison. Permanent surrender of license and forever prohibited from practicing medicine in the State of Michigan.

John W. Moore, MD, Detroit. License suspended for ninety (90) days plus a one(1) year probation period. To become effective sixty (60) days after service of final order.

James A. Martin, MD, Fenton. Suspended license for three (3) months and surrender of CSR for one (1) year. Order to take effect no later than 10/3/78.

Rolando A. Mateo, MD, Royal Oak. Board ordered six (6) months suspension of license. Appealed to Circuit Court which in turn reduced penalty to thirty (30) days, which commenced 8/1/78.

Preston W. Ports, MD, Three Rivers. License revoked by Final Order, 9/7/76 and Final Order, April 7, 1977. Appealed in Circuit Court. Board's decision upheld June 6, 1978.

Other actions of Michigan Medical Practice Board:

Charles J. Danek, MD, Ann Arbor. Reinstatement of limited license to full licensure.

Which Man Are You?

Theodore Roosevelt, 26th president of the U.S. (1901-1909), emphasized the need for persons to try to improve politics rather than merely find fault:

"It is not the man who sits by his fireplace reading his evening paper and saying how bad our politics and politicians are who will ever do anything to save us; it is the man who goes out into the rough, hurly-burly of the caucus, the primary, the political meeting, and there faces his fellows on equal terms.

"The real service is not rendered by the critic who stands aloof from the contest, but by the man who enters it and bears his part as a man should."

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Deaths

Roswell G. Burroughs, MD
Beverly Hills

Roswell G. Burroughs, MD, age 70, Beverly Hills, died Sept. 10. Doctor Burroughs maintained a medical practice in Lathrup. A graduate of the Wayne State University School of Medicine, Detroit, he served with the U.S. Army Medical Corps during World War II.

Jack L. Bush, MD
Ann Arbor

Jack L. Bush, MD, Ann Arbor, died Sept. 7 at the age of 47. An associate director of clinical therapeutics for Parke, Davis & Co., Doctor Bush graduated from the University of Michigan Medical School. He was affiliated with St. Joseph Mercy Hospital, Ann Arbor, and was a fellow of the American College of Obstetrics and Gynecology.

Joseph M. Erman, MD
West Bloomfield

Joseph M. Erman, MD, age 79, West Bloomfield, died Sept. 2. Doctor Erman was a graduate of the Wayne State University School of Medicine.

Samuel A. Fiegel, MD
Kalamazoo

Samuel A. Fiegel, MD, Kalamazoo, died July 25 at the age of 69. Doctor Fiegel was a graduate of the University of Michigan Medical School and was affiliated with Sturgis Memorial Hospital. He was a past delegate to the MSMS House of Delegates as well as a past president and secretary of the St. Joseph County Medical Society. He was on the board and treasurer, University of Michigan Medical Center Alumni Association.

Ivor D. Harris, MD
Grosse Pointe Farms

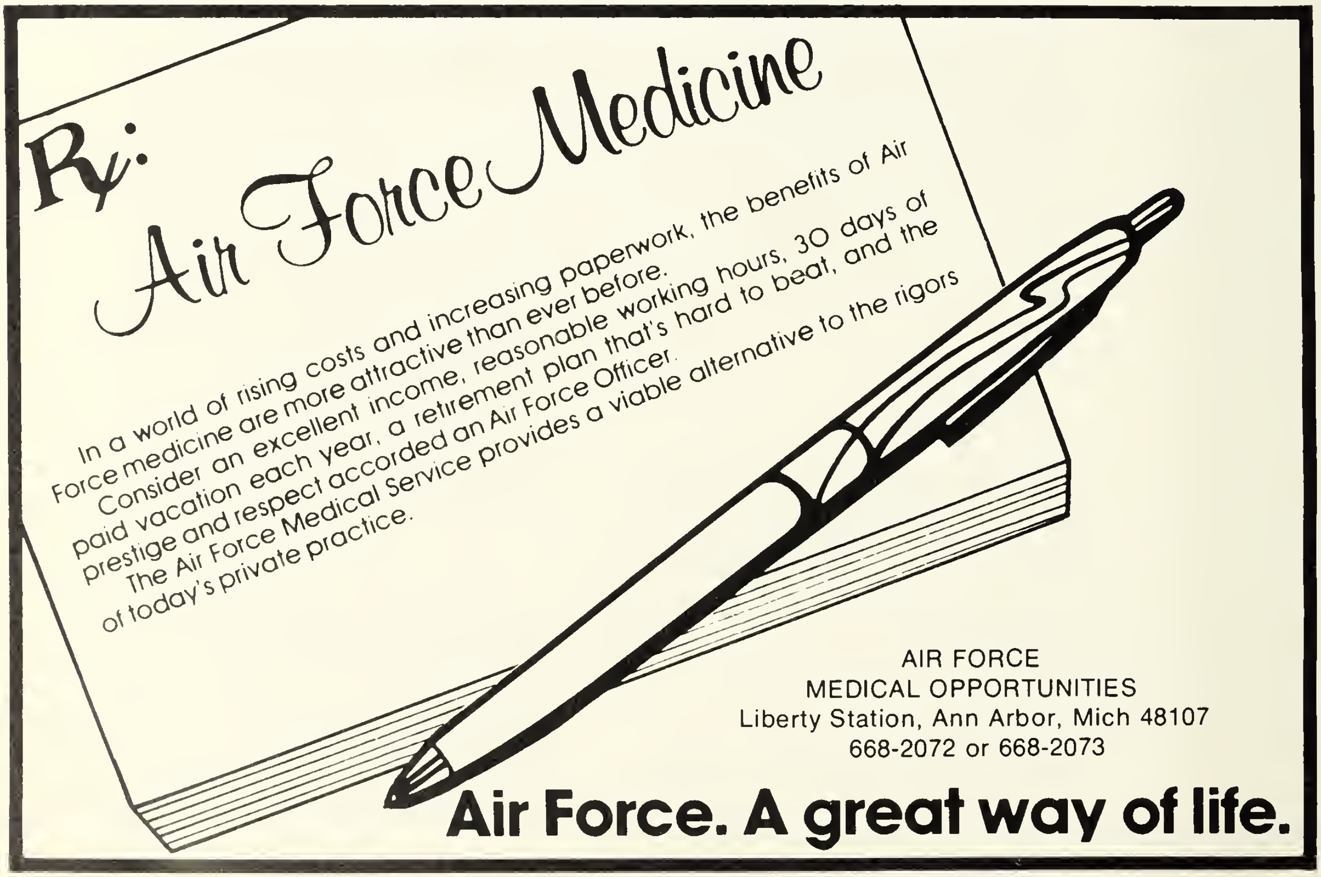
Ivor D. Harris, MD, 65, Grosse Pointe Farms, died Sept. 9. A radiologist, Doctor Harris was a graduate of the University of Virginia Medical School and was an instructor there and at Wayne State University. He was affiliated with Delray, Oakwood and Wyandotte hospitals. He was a past president of the Michigan Radiological Society and a board member of the Michigan Cancer Foundation. He also was a member of the American College of Radiology.

Harold Heffron, MD
Manitou Beach

Harold Heffron, MD, Manitou Beach, age 84, died August 28. A general practitioner, Doctor Heffron received his medical degree from the Wayne State University School of Medicine. He was a member of the American Academy of Family Physicians and the Pan Pacific Surgical Association.

Ralph C. Rueger, MD
Ann Arbor

Ralph C. Rueger, MD, Ann Arbor, died June 11 at the age of 77. Doctor Rueger graduated from the Wayne State University School of Medicine, specializing in gynecology. He was affiliated with Grace Central Hospital, Detroit and Cottage Hospital, Grosse Pointe. Doctor Rueger was a treasurer for the Wayne County Academy of General Practice and a past secretary of the General Practice Section Council, Wayne County Medical Society.



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Beltone Hearing Aid Center
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Coldwater, Michigan 49036
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Positions open

WANTED: INDUSTRIAL PHYSICIAN full or part time, large industrial corporation, salary competitive, malpractice insurance, excellent employee benefits, including life insurance, hospitalization, major medical insurance, accident-sickness insurance, long-term disability, dental insurance, liberal vacation and retirement programs, stock investment plan, CME time. Send curriculum vitae and references to P.O. Box 29834, Detroit, MI 48229.

ANESTHESIOLOGIST — Seventy-man multi-specialty clinic in northwest Lower Michigan. Winter-summer resort area seeks fifth anesthesiologist to join four board certified anesthesiologists. Training in respiratory care and cardiac anesthesia required. Good salary and excellent benefits. Contact: J. R. Rasmussen, MD, c/o Burns Clinic Medical Center, P.C., 560 West Mitchell St., Petoskey, MI 49770.

NEEDED: CREATIVE PHYSICIAN EDUCATOR to assume an excellent position and opportunities as associate director of a family practice program which is part of a 30-physician residency. This center is located within the new Medical Tower adjacent to an 1150-bed teaching hospital in Indianapolis, Indiana. Excellent salary and benefits available. For further information, send C.V. to: Director of Family Practice Education, Methodist Hospital, 1604 North Capitol Avenue, Indianapolis, Indiana 46202.

FULL TIME MEDICAL DIRECTOR for position in medium size industrial medical facility, Kalamazoo, Michigan. Excellent clinic facilities; staff includes full registered nursing coverage. Previous industrial experience desirable, but not mandatory. Full corporate benefits, including malpractice insurance, company paid insurance, top notch fringe benefits. Position open December 1, 1978. Please send resume, with minimum salary requirements, in confidence to: M. Hranchook, MD, Divisional Medical Director, Fisher Body Division, GMC, 30001 Van Dyke, Warren, MI 48090. 313/575-5976.

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PETOSKEY — Unusual opportunity for Board certified or Board eligible psychiatrist to join one of the nation's finest multi-specialty group practices in year-round resort area. Excellent skiing and winter sports, magnificent sailing and all summer recreational pursuits, plus fine hunting and fishing. Full range inpatient and outpatient psychiatric services, and connection with Community Mental Health Service Facility. Excellent benefit package, salary competitive, incentive plan after first year. Enclose curriculum vitae and address inquiries to: L. Jerome Fink, MD, FAPA, Chairman, Dept. of Psychiatry, Burns Clinic Medical Center, PC, 560 W. Mitchell, Petoskey, MI 49770.

MARQUETTE, MICHIGAN — Expanding referral center has positions available both immediately and in the future for an allergist and a part-time director of medical education. Also needed are additional physicians in the following specialties: obstetrics, gynecology, hematology, oncology, pulmonary disease, primary and consultative internal medicine, and dermatology. Fully equipped hospital with: advanced lab facilities, CT Scanner, active cardiovascular surgery, active participation in the training of MSU medical students, and a family practice residency beginning in 1979. Current staff of 79 solo and small group private practitioners; 87 percent board certified; average age of active staff is 42. University town on unspoiled Lake Superior with all recreational activities. Send curriculum vitae or call: John D. Wojcik, MD, Recruitment Committee, Marquette General Hospital, 420 W. Magnetic Street, Marquette, MI 49855. 906/228-9440, extension 434.

TROY — PSYCHIATRIST WANTED for a private Out-Pt. Clinic. Bd. eligible or Bd. certified. Multidisciplinary, dynamic and very active practice. Salary dependent upon experience and negotiable. Excellent working conditions and location. Please contact Y. M. Alkar, MD, Medical Director, 2151 Livernois, Troy, MI 48084 or call 313/362-4144.

FAMILY PRACTITIONERS, INTERNISTS, and/or OB-GYNs needed in growing, prosperous Dutch community to join a Board Certified family physician in existing practice, or solo available. Excellent economy with medical education, recreational lakes, and ski resorts within 20 mile radius. Will help solo practice to start out. Guarantee net income of $40,000 for first year partner. Call Grand Rapids, MI, 616/531-9803 between 9 and 11 p.m.

POSITIONS AVAILABLE — With offices in Lansing and Oak Park, there are openings for physicians board qualified as internists, family physicians or psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently between forty-five and fifty-five thousand per year, plus 23% fringe benefits, including life, accident, long term disability, dental, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. Liability insurance not necessary. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7830.

Positions wanted

DOCTOR'S ASSISTANT — Male nurse, with excellent experience in acute setting, seeking position with one or group of physicians. Design responsibilities to reduce your work load. SE Michigan but not Detroit metro area. 313/475-1183. 505 Maywood, Chelsea, MI 48118.

UROLOGIST, 36, FLEX, training in major midwest university program, excellent surgical experience, seeking group, partnership or solo practice. Available July, 1979, W. I. Lin, MD, 5916 Culzean Drive, #505, Dayton, Ohio 45426. 513/837-5158 or 268-6511.

PHYSICIAN'S ASSISTANT — three years of primary care experience. Seeking employment in the Grand Rapids, Muskegon, Western Michigan area. Solo or group practice. Nationally certified. Write MSMS, Box 17, 120 W. Saginaw, East Lansing, 48823.

FAMILY PHYSICIAN, residency trained, board certified and experienced desires to join a group practice located in northern or wes ern lower peninsula. Would prefer a location in cities of 20,000 or more. Contact J. Jarvis, 1149 Jefferson, Shakopee, Minnesota 55379. 612/455-7655.

Miscellaneous

BEAT THE WINTER — come to the sunbelt. Our clients range from solo practitioners seeking associates, to single and multi-specialty group expansions, to practices being vacated by retiring physicians. These situations offer excellent growth, low crime, warm climate, varied recreational activities, and attractive income and perk packages. For assistance in your move and/or opportunities in your specialty send your CV, describing the situation you seek, to MEDICAL SEARCH, 3955 Pleasantdale Road, Atlanta, GA 30340.

MEDICAL AND DENTAL OFFICE to be built. Tremendous growth location — 16 Mile Road, just east of Ryan Road, Sterling Heights. Call B. Monast at 313/542-7100.

MPMLC SURPLUS CERTIFICATE for sale. Basic value $1,000. Please call from 9-4:30 Monday through Friday. 616/343-3361.

NEW MEDICAL SPACE — 1,900 sq. ft. available in Southfield Medical Dental complex. Prime location. Please call 313/352-5440.

SECURITY TAPES: Now you can learn the basics of good security on cassette tapes. #1 Basic Home Security; #2 Office Security Practices; #3 Personal & Vehicle Security. $10 each or all three for $25. Personal Security Associates, Dept. RZ, 2646 Cheltenham Rd., Toledo, Ohio 43606.

AU SABLE RIVER/NEAR GRAYLING. 1,230-foot frontage with three modern cabins completely furnished. Large cabin sleeps eight. Beautifully wooded property with mature trees. Facilities are ideal for three or four family ownership or as an organizational retreat. Will consider dividing. Land contract terms. Brochure on request. EACO Realty, Box 21203, Lansing, MI 48909. 517/686-5660.

GROUP PRACTICE NEEDED — all new medical center in prime location of Brighton. 2000 square feet office unit, includes four exam rooms or more, private office and entrance, laboratory, excellent parking, ideal to accomodate one or two doctors. Immediate occupancy. Call Davis Professional Bldg., 313/229-2752.

Table 1. Insurance plans used by members

Participants in MSMS plan	505	67.7%
Participants in other BCBS plan	136	18.2%
Insurance with private company only	105	14.1%
	746	100.0%

Table 2. Respondents with health insurance through a private company only:

With co-payment/deductible policy	52	60.5%
With catastrophic coverage only	11	12.8%
With first dollar coverage	19	22.1%
With co-payment/deductible and catastrophic coverage	4	4.7%
	86	100.1%

19 respondents in this category did not answer this question.

Table 3. Respondents prefer MSMS coverage be through:

	With MSMS Plan		Other BCBS Plan		With Private Insurance only		All Respondents	
BCBS	231	51.2%	49	49.5%	20	22.5%	300	46.9%
Private Company	193	42.8%	40	40.4%	65	73.0%	298	46.6%
No preference	27	6.0%	10	10.1%	4	4.5%	41	6.4%
	451	100.0%	99	100.0%	89	100.0%	639	99.9%

Totals may vary from other tables because of respondents not answering this question.

MSMS survey shows members split over group insurance carrier

By John Richards, Chief
MSMS Bureau of Economics

At the request of the Task Force on a Group Health Insurance Plan, the Bureau of Economics recently completed a sample survey of MSMS active members regarding their opinions on the group health insurance offered by the Society through Blue Cross/Blue Shield of Michigan (BCBSM). This Task Force has been studying alternatives to the present coverage, as directed by the special House of Delegates in October of 1977.

Respondents split over Blues

The most significant finding of the survey is that the 746 respondents are almost evenly split on the question of whether MSMS should offer coverage through BCBSM or a private insurer. Given the condition that benefits and premiums would remain the same, 46.9 percent state a preference for BCBSM and 46.6 percent favor a private company. (Detailed charts and the percentage of "no preference" responses are shown above.)

Large number have co-pay

A second finding of the survey is that a large percentage of those physicians not having BCBSM insurance either through MSMS or another group carry co-pay/deductible type coverage. The next most common type of insurance carried by this group is first-dollar coverage, followed by the catastrophic type. The desirability of the deductible/co-pay policy is further displayed by the response of those physicians carrying MSMS insurance. Approximately 47 percent responding in this category felt one way to improve the present coverage would be to include this feature.

(Greater details are available by calling MSMS headquarters.)

President's page

Let's set and adjust fees reasonably

Louis E. Heideman, MD
MSMS president

Doctors are human beings . . .

responding in the same way as other people to economic pressures and to the games imposed on us. We want maximum security, recognition and respect. On a one-to-one basis with our patients, we are kind and considerate. But these qualities are difficult to maintain when we are confronted by the faceless "third-party." Gamesmanship seems to be part of our American scene. We have been forced to recognize this to learn the game. These realities necessitate a review of their implications for us as individuals and for our profession — so that we make some conscious and deliberate decisions rather than drifting, encountering unsatisfactory conditions and then reacting to them.

In the old days, which were not necessarily good, our transactions were direct. We made needed adjustments in our fees. This is to a large extent still true for the patients we see in our offices, although the third party may enter those transactions involving laboratory work.

But when we receive our fees from a third party we demand the same fee as our colleagues get and are unhappy when there is any differential. This is understandable in terms of the indirect payment by an agency or corporation processing amounts of money for their subscribers and the reality that the same dollars are paid for a given benefit by all subscribers and therefore the same fees should be paid for equivalent services.

Our office managers and financial advisors tell us to raise our fees so we will be able to weather the situation should another freeze develop. There is, of course, an element of a self-fulfilling prophecy in this, but that is another matter.

And then, we are tempted to test the screen by increasing fees and to charge more plus establish a higher base in the computer to anticipate profile adjustments.

The implication of these relationships is that they tend to push fees up to keep up with the Joneses, rather than to compensate us appropriately for our services, and thus provide the base for complaints about physician earnings. I do not believe that physicians are overpaid, and in some instances we are under paid.

But we provide a base for charges that is hard to refute, especially when very few of us see the data on which the charges are based. As each of us looks at our individual activities, this does not become evident. The net result is increasing pressure for replacement of UCR by a negotiated fee schedule with no indication at this point of who will negotiate such a schedule.

The established policy of MSMS is to endorse the concept of usual, customary and reasonable (UCR). To retain this, we must each act responsibly in our own fee-setting practices. We must act in a rational manner, adjust our fees reasonably and not try to beat the system.

Physicians are bright, capable and responsible human beings and function effectively with due regard for the best interests of our patients — especially when we feel we are treated equitably.

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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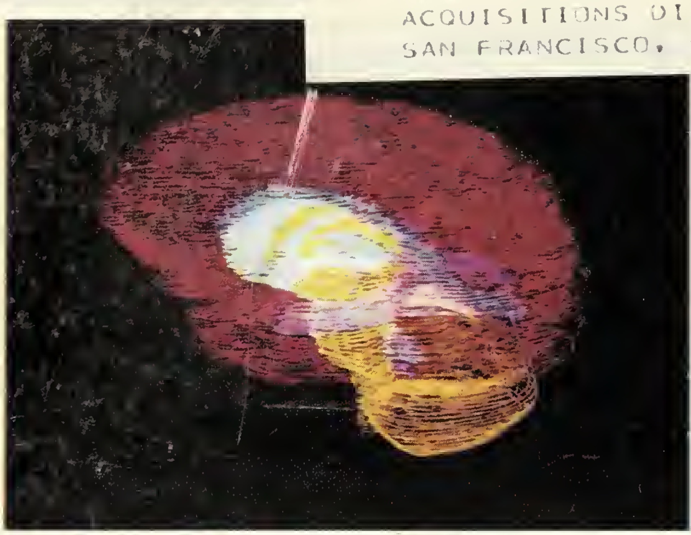

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PSULES

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BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine Medigram

VOL. 77, NO. 33 NOVEMBER 22, 1978

MSMS receives FTC subpoena

The Federal Trade Commission has subpoenaed MSMS for certain information in regards to MSMS relationships with Blue Cross/Blue Shield of Michigan. The subpoena, delivered Nov. 10 to MSMS headquarters, links the MSMS investigation with a national effort "to determine whether control of the National Association of Blue Shield Plans and/or individual Blue Shield plans, or participation in such control, by physicians, medical societies, and/or the American Medical Association, may constitute unfair methods of competition and/or unfair acts or practices, including price fixing, in violation of Section 5 of the Federal Trade Commission Act."

"As a part of its national program," says A. Stewart Kerr, MSMS legal counsel, "the FTC apparently is interested in ascertaining whether MSMS has attempted any improper pressures upon Blue Cross/Blue Shield of Michigan."

ASM attendance tops 2,000

Record numbers registered for the 1978 MSMS Annual Scientific Meeting Nov. 7-8-9 at the Detroit Plaza. They included 1,604 physicians (among them 277 speakers and course directors), 106 guests and 403 exhibitors for a grand total of 2,113 registrations. There were 3,170 total course registrations for the 58 courses offered and 9,510 hours of Category I credit were awarded the doctors attending the courses. Work has already begun on the 1979 meeting, which is planned for Nov. 13-14-15 at the Hyatt Regency Dearborn. Chairman for that meeting will be Samuel M. McMahon, MD, MSU associate professor and director of medical education at Ingham Medical Center in Lansing.

CAPSULES/continued

DONALD C. SMITH, MD, MSMS member and former director of the Michigan Department of Mental Health, is new vice president for accreditation of the Joint Commission on Accreditation of Hospitals (JCAH). He is one of three JCAH vice presidents in the new reorganization plan announced in AM News Nov. 10.

* * *

ARCHIE W. BEDELL, MD, St. Clair Shores family physician, and Kenneth J. Ray, MD, Trenton family physician, are candidates for the president-elect of the Wayne County Medical Society. Elections will be held by mail ballot and results will be announced Jan. 8.

* * *

THE NEXT "HOUSECALL" live phone-in medical question and answer show will be broadcast Dec. 20 by Detroit's Channel 56. This is a change from the original date of Dec. 5. On the physician panel to answer questions will be Ed Guise, MD, orthopedic surgeon and Detroit Lions team physician; Harold Kendrick, MD, Pontiac family physician; and Arnold Weissler, MD, WSU internal medicine department chairman.

Physicians may need new drug licens

Michigan physicians soon will be receiving, in conjunction with their license renewal forms, a letter from the Michigan Board of Pharmacy requiring those offices dispensing drugs to obtain a Drug Control License. Licensees are reminded that the Drug Contro License is not to be confused with the controlled substance registration required by state law.

The initial license fee is $25 and $15 for annual renewal. Under the Board of Pharmacy edict, the license shall contain the name and address of dispensing prescriber and the license must comply with all of the labeling and container specifications of the Pharmacy Acts. The MD also would have to list th 100 most common drugs in his place of practice; record on the patient's charts a complete record of drugs dispensed by prescriber or drugs dispensed under his/her delegatory authority. The significant concern with the Board of Pharmacy decision is the requirement for all dispensing physicians to comply with rules which were initially established for pharmacies.

Physicians who wish to voice their concerns or objections to this requirement should write their local legislator at: Representative ________ or Senator ________, State Capitol Building, Lansing, 48901. Or to the Governor and particularly to: Mr. Carl Cross, Executive Director, Michigan Board of Pharmacy, 905 Southland, Lansing, 48909.

John A. Doherty dies

John A. Doherty, East Lansing, executive vice president of the Michigan Health Council for more than 20 years, died Nov. 17 at the age of 60. Mr. Doherty had won the MHC national prominence in health career education and physician placement fields. The MHC was founded by MSMS in 1943. Memorial gifts may be sent to the John A. Doherty Scholarship Fund, MHC, Stephen Nisbet Building, 1407 S. Harrison Road, East Lansing, 48823.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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Managing Editor: Judith Marr

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DAW MSMS RESPONSE

Te Statewide Health Coordinat-
ig Council will meet Dec. 14
ad 15 to give final considera-
tion to the Preliminary State
ealth Plan. MSMS responses
t key issues in the plan have
en submitted to the SHCC Ad
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veral MSMS considerations
ve been adopted and will be
cluded in the Committee's
commendation's to the full
CC. The two-day SHCC meet-
ig will be held at the Uni-
rsity Club, Lansing.

MS responses to 12 specific
bject areas in the Prelimi-
ry Plan are reported in the
cember issue of Michigan
dicine, with commentary by
nneth J. Ray, MD, chairman,
MS Health Planning Steering
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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
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Here is a status report on current MSMS litigation

By A. Stewart Kerr, MSMS legal counsel

MSMS has been doing battle on a variety of fronts in recent months to relieve the physician from certain discriminatory practices of BCBSM. This would ensure the patient equal treatment within the contract and the free choice of physicians.

These efforts recently have met with some success. As you are aware, the Blues filed suit in 1975 against the Insurance Commissioner (Insurance Commissioner v. BCBSM) when the Commissioner reduced a BCBSM rate request by $46,000,000 because he found the request was based in part on waste in health care costs. The Insurance Commissioner also rejected BCBSM's proposed increase in physicians' screens as "not justified." Blue Cross-Blue Shield contended that the Insurance Commissioner lacked authority to penalize BCBSM through the $46,000,000 rate reduction.

MSMS filed an extensive brief in this case, arguing that the $46,000,000 rate reduction violated the 1939 Enabling Act which set up the Blues and forbids any health care plans which interfere with or interrupt the physician-patient relationship and the freedom of the patient to select his own physician. We also argued in the case that the Insurance Commissioner had no authority to regulate fees paid to physicians by BCBSM.

The Michigan Supreme Court agreed. The Court held that the Insurance Commissioner was without authority to disapprove rate increases when its actions would have the effect of invading the physician-patient relationship, would usurp the physician's control over the practice of medicine or limit the subscribers' free choice of hospitals and doctors. The Court also stated that the Insurance Commissioner had no authority to approve rates of payment to physicians.

This is a victory for physicians in this State. The Court, in effect, held that prospectively, BCBSM may not offer health care plans which violate the

(continued)

CAPSULES

MSMS MEMBERS' RESPONSE is excellent in the first few weeks following mailing of 1979 dues statements, according to MSMS controller M. C. Lee. Nearly 500 members remitted their dues within two weeks after the first statements went in the mail. Members are urged to pay their MSMS, AMA, and county dues before Dec. 31 for a 1978 tax deduction.

* * *

PHYSICIANS WHO WOULD LIKE to spend time in Lansing as a medical consultant to state legislators are urged to contact MSMS headquarters. Volunteers are being sought to serve under the revamped "Doctor of the Week" program. The new version will have MDs at work with legislators for a day or two when specific issues are raised needing expert knowledge. Please contact Gary Anderson at MSMS headquarters.

Enabling Act. Also the Insurance Commissioner has no authority to approve or disapprove any rates which BCBSM wishes to establish for physicians. The case has a favorable impact on our other litigation against BCBSM, particularly the psychiatric suit. In that case, as you are aware, we are contending that the 1977 cut-back in out-patient psychiatric benefits amounts to an interference with the doctor-patient relationship and the freedom of the patient to select his own physician.

MSMS continues to press both our psychiatric and otolaryngology suits. The Blues' motion to dismiss our psychiatric suit in Oakland County was summarily rejected. We are proceeding on discovery in the case. On the otolaryngology suit, we are continuing to vigorously prosecute the case through discovery. We are still awaiting a decision on the defendant's motions to dismiss. Judge DeMascio will probably so dismiss. We then intend to appeal to the 6th Circuit at Cincinnati.

The national pharmacy case was argued before U.S. Supreme Court on Oct. 11. This case involves the extent to which Blue Cross-Blue Shield organizations may fix prices and discriminate against non-participating professionals free of antitrust liability. As you know, we filed an amicus brief in this case and have been in steady contact with lead counsel for plaintiffs to determine its progress.

On other fronts, MSMS recently filed an amicus brief in the Friedman case on behalf of Seymour Friedman, MD, urging that the Supreme Court hear his appeal. The case touches on the critical question of to what extent a physician may sue an attorney for bringing a frivolous medical malpractice suit. If the Supreme Court accepts the case, we will file another extensive brief.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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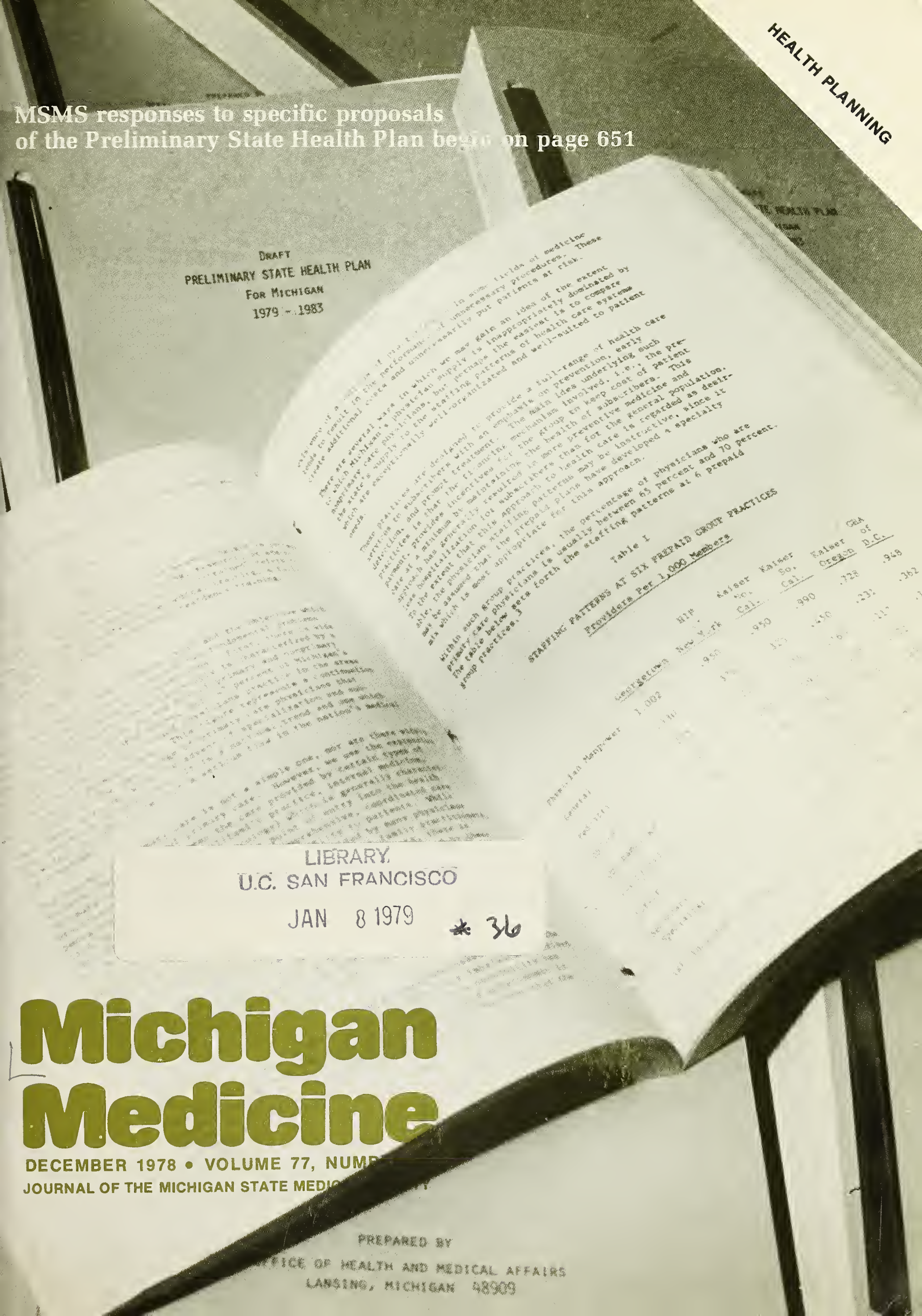
MSMS responses to specific proposals of the Preliminary State Health Plan begin on page 651



DRAFT
PRELIMINARY STATE HEALTH PLAN
FOR MICHIGAN
1979 - 1983

Table I
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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

Michigan Medicine

The 764-page Preliminary State Health Plan is the object of close scrutiny by all interested parties — including Michigan physicians. See special section beginning on facing page.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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Opportunity or threat, health planning needs MDs' action

Doctor Ray

By Kenneth J. Ray, MD
Trenton

Early in 1975 Congress enacted Public Law 93-641 entitled the National Planning and Resources Development Act of 1974. The preamble of this document sets the thrust of this legislative effort. It says, "The achievement of equal access to quality health care at a reasonable cost is a priority of the federal government."

Obviously this statement contains three components which may be in conflict with one another: equal access, quality health care, and reasonable cost. At some point, access and quality must yield to cost considerations.

In order to strike an appropriate balance between these opposing forces, the federal government will establish over 200 health systems agencies (HSAs) across the country. Superimposed on these agencies will be state health planning and development agencies (SHPDA) which will serve as an arm of each state's government.

In addition to this, each state will have an appointed Statewide Health Coordinating Council which must approve the plans of all the HSAs within the state as well as the plans and actions of the SHPDA (which in Michigan is the Office of Health and Medical Affairs). It may ultimately prove a blessing to medicine that some of the hard decisions of the future will be made by a consumer majority at all levels.

A real challenge

Throughout the country, organized medicine has seen Public Law 93-641 as a real challenge. On one hand, it may pose a threat to the quality of medical care. On the other hand, it may offer an opportunity for appropriate cost containment. To ensure prudence in the future course of events, physicians must become involved.

Some state medical societies were quick to respond to Public Law 93-641. Texas established a system to monitor all HSA and state activities by mobilizing their medical auxiliary. Minnesota established a physician organization which duplicated the structure of local and state planning agencies. In this way, they were able to keep abreast of and participate in a decision-making process. Both of these programs have been very successful.

During the past few months, the Michigan State Medical Society has been organizing a health planning program as mandated by the House of Delegates in May, 1978. The purpose of this program is to assist local physicians and component societies in their relationships with HSAs, and to monitor and respond to planning activities at the state level. This is not a simple task. It will require a significant investment in time and money.

The focus of this activity will be the newly-formed MSMS Physician/HSA Support Center patterned after the previous PSRO Support Center. MSMS is currently in the process of acquiring staff and establishing programs. It is anticipated that one staff person will devote a major share of time to activities of the HSA of southeastern Michigan while another of the staff will primarily devote efforts to the nine other HSA's in Michigan. Sherry Wellman in the MSMS Department of Government Relations will monitor activities at the state level.

It is likely that a permanent organization at the local level will be developed combining the best features of the Texas model and the Minnesota model. In addition, the planning committee is considering the use of appropriately selected retired physicians on a paid basis.

HSA characteristics vary

In Michigan, as in the rest of the country, different HSAs have different characteristics. In areas dominated by labor and big business, there is a tendency to exclude physicians who identify with organized medicine or to dilute their representation with a host of allied health care providers. In the more rural areas, physicians are encouraged to participate, and their views are respected. Each HSA has its own personality. Some may require a firm, almost aggressive approach by physicians, while others may respond to a gentle nudge.

Organization at the local level may take many forms. In the seven southeastern Michigan counties, the component societies formed a committee to participate in the local HSA. The activities of this committee are financed by contributions from the seven county societies, at a rate of $2 per member. It is anticipated that this committee may provide assistance in organizing other HSA areas and expertise in responding at the state level.

HSAs will not disappear. Physicians must become involved in the health planning process. They must familiarize themselves with the local Health Systems Plan covering the next five-year period, as well as the Annual Implementation Plan. They must identify their areas of concern in the State Health Plan. And finally, they must organize to have continuous intelligent input into all these programs. An article in the Oct. 30 issue of *Medical Economics* provides several vignettes, emphasizing the need for physician participation in HSAs.

Public Law 93-641 expresses the noblest of purposes, but it has the capacity for great change. In the simplest of terms, this law is a blueprint for the rationing of medical services. Physicians must play a role in this determination.

(Michigan's Designated State Agency — the Office of Health and Medical Affairs of the executive branch of the state government, has formulated its Preliminary State Health Plan, according to the federal blueprint for health planning described above by Doctor Ray. For official MSMS responses to key sections of that preliminary plan, turn the page.)

Doctor Ray is chairman, MSMS Health Planning Steering Group.

How new state health plan would interface with other health care programs

By Judith Marr
Managing Editor

As the preliminary state health plan is considered across the state, one of the big questions for the medical profession is how this state plan will "fit in" with other programs already underway.

These include the health systems agencies (HSAs), the new Public Health Code, PSROs — all of which have "pieces of action" in the health planning area.

According to Kenneth J. Ray, MD, Trenton, chairman, MSMS Steering Group on Health Planning (see accompanying article), "there really is a turf battle going on."

HSAs are the local units of authority designated to carry out the goals of the federally required state health plans. In Michigan the HSAs have come into being before the State Health Plan which is to guide them.

And then there are the Public Health Code and PSROs.

The health code

Doctor Ray, reporting in September to the MSMS Council, said, "The new Public Health Code is far from complementary to the Preliminary State Health Plan."

The code calls for the Department of Public Health to annually identify priority health problems in the state. From these priorities, the department is to prepare a proposed list of basic preventive, personal and environmental health services to be "made available and accessible to all residents in need of the services in this state without regard for place of residence, marital status, sex, age, race or inability to pay."

The list of basic health services must be based on the "capabilities of the health related arts and sciences and upon criteria related to health needs, resources, and performance and shall take into account the services provided by private practitioners and private providers of health services."

The proposed list of basic health services, how it was derived, and proposed program statements are then included in the department's annual budget request and submitted to the legislature.

The confusion of conflicting plans and the power struggle resulting are further described by Doctor Ray, MSMS chief spokesman in the health planning area.

"Eight HSAs in the state are trying to draft health systems plans right now for their own regions, which the statutes say must be a part of the state plan.

"The public health department already has begun a process designed to implement the health code's requirement to identify basic health needs in the state. Although the health department has advised the local and district health departments to work with HSAs in this endeavor, there may be a built-in conflict between the two groups.

"The legislature itself will soon begin writing the 1979-80 appropriations bills for the public health department. It will have an interest in local health department recommendations.

"It means the ultimate determination of health planning and implementation will be political — and those who are most active in the battle will end up with most influence."

The PSRO view

Michigan's 10 PSROs currently are busy developing a system of quality health care assurance through peer review.

Comments by Mendle "Gene" Adams, director of public relations and information for the Western Michigan PSRO, may be representative of the PSRO viewpoint of the new health planning giant, the preliminary state health plan.

He said, "In reading through the 760 pages of this document, little reference to the existing fact of PSROs' utilization review and medical care evaluation could be found.

"Even though PSROs are mandated by Congress and therefore are under the jurisdiction of the federal government," he commented further at the request of the Michigan Department of Management and Budget, "the state has chosen to tell the federal government what it 'should do' instead of dealing with the state government's resistance to full PSRO implementation in this state.

"Instead of asking for Congress to 'pass a law' (to establish a new state health plan), it would seem the responsible course would be for the state to 'obey the law' (already in effect which has physicians statewide working to ensure good health care)."

Mr. Adams declared he hoped the final draft of the preliminary state health plan "would not scoff at the idea of doctor reviewing doctor." He pointed out the PSRO guidelines for judging quality of care are developed in each local community, but on the basis of national criteria.

"The public interest would best be served by supporting and cooperating with the system now in place, instead of having a state attitude of frustrating that system and passing the buck to Congress for it not being workable," he said.

"We recommend," he said, "a simple statement of policy that the state of Michigan will cooperate with the locally operated PSROs as set up under PL 92-603 in every way, to assure the citizens of Michigan that they will have access to quality health care at a reasonable cost."

MSMS responds to recommendations of Preliminary State Health Plan

The proposed policies and recommended actions contained in the boxes are those extracted from the Preliminary State Health Plan as drafted by the Office of Health and Medical Affairs. MSMS responses are alongside.

Background

MSMS responses to the Preliminary State Health Plan were developed by the MSMS Steering Group on Health Planning, chaired by Kenneth J. Ray, MD.

The Steering Group carefully screened all recommended actions in the 764-page preliminary plan. There were 75 recommended actions dealing with health status issues; 98 recommended actions on health systems issues; and 17 on the environment. The MSMS group identified 12 areas of concern which would have direct and, in MSMS opinion, a detrimental effect on quality of medical practice in Michigan.

MSMS responses, and those of other interested parties, were considered by the Plan and Policy Development Committee of the Statewide Health Coordinating Council during October and November and by the entire SHCC in December. The final document approved by the SHCC is then subject to approval by the State Legislature and the Governor. The State Health Plan will become the principle guide for development of state health programs and for allocation of resources to health activities in the state.

— Sherry N. Wellman

PROPOSED POLICY B2(A)-2

For the years 1978-1983, the number of residency positions available in Michigan hospitals should not exceed the number available in 1977. In addition, the number of positions in primary care programs (family/general practice, pediatrics, internal medicine, obstetrics/gynecology) should, by 1981, increase by at least 15 percent.

RECOMMENDED ACTIONS

B2(A)-2.1: **The Office of Health and Medical Affairs should promote the development of a graduate medical education planning system which consists of those institutions, organizations, and agencies involved in graduate medical education. Such a system should:**

a. **determine the optimum number of residency positions in Michigan;**

b. **determine the optimum number of residency positions in Michigan for each specialty;**

c. **develop a methodology for allocating residency positions, by specialty, among the state's hospitals and other training sites; and**

d. **initiate and pursue discussions and agreements with the states surrounding Michigan with a view towards conducting graduate medical education planning on a regional basis.**

The activities of the planning system should be consistent with and guided by the goals and objectives appearing in the health manpower component of the State Health Plan.

Health personnel resources — Residency positions

The Michigan State Medical Society cannot support either of the two proposals dealing with limitation or allocation of residency positions in the state.

Both proposed policy B2(A)-2 and B2(B)-2 fail to recognize the fact that residency training programs are national in scope and are not conducive to limitation or allocation by a single state. The difficulties encountered with the existing Statewide House Officers Training System probably serve to illustrate the point.

Additionally, to increase primary care specialty programs by 15 percent will mean a subsequent reduction in all other specialty programs if the total number must remain at 1977 levels.

Given the aging nature of the American population, MSMS questions the need to expand the number of obstetricians and pediatricians. Although inclusion of the two specialties in the definition of primary care is recognized as currently appropriate, realistic planning for the future needs of the population should be more specific than simple adoption of existing definitions.

MSMS does not believe the proposed policy of B2(A)-2 recognizes the national scope of the issue or the aging nature of the population and therefore recommends deletion of the policy and recommended action.

PROPOSED POLICY B5-6

By 1983 the rate of increase of per capita expenditures for physician services should be no greater than the rate of increase of per capita gross national product.

RECOMMENDED ACTIONS

B5-6.1: **Blue Cross and Blue Shield of Michigan and the Medicaid pro-**

(Continued next page)

Health care costs — Reimbursement

The Michigan State Medical Society must take strong exception to all three of the recommended actions.

B5-6.1 directs third party payers to lower reimbursements for unidentified procedures which are ordered more frequently than can be medically justified. MSMS believes this completely fails to address the more important and appropriate issue of encouraging both patients and physicians to utilize ambulatory care services when medically effective.

MSMS and the Department of Social Services, with legislative approval, have embarked on a program which encourages treatment of Medicaid patients in an office setting rather than in expensive emergency facilities. The last part of B5-6.1 does appear to suggest a similar approach and should be clarified.

B5-6.2 is entirely inappropriate for a first year state health plan. The basis for the recommendation is vague, particularly in regard to the disruptive effects it would have on the availability of radiology and pathology services in the state.

The Michigan Society of Pathologists and the Michigan Radiology Society have repeatedly offered to cooperate in studies to identify problems in utilization control and unit costs. MSMS believes that such studies certainly need to be undertaken prior to consideration of such drastic alterations in physician reimbursement.

B5-6.3 should be deleted from consideration at this time.

gram should alter their reimbursement schedules for physicians to lower the maximum allowable fee for those procedures for which there is evidence that the procedure or service is ordered more frequently than can be medically justified. Where substitute procedures or services exist which are less costly and as safe and effective when appropriately provided, maximum allowable fees for those alternatives should be raised.

B5-6.2: **Third-party payers — in particular Blue Cross and Blue Shield and the Medicaid program — should pay for services of radiologists and pathologists providing services to hospital patients when those serviced are billed as part of hospital charges and when the hospital establishes a maximum annual amount which it will pay for these services; third-party payers should establish reasonable maximum annual limits which they will accept as allowable costs.**

B5-6.3: **Third-party payers should reimburse all physicians at the same payment level for the same primary care service (except when that service is provided on a referral from another physician).**

Health care costs — Second surgical opinions

The Michigan State Medical Society is strongly opposed to any proposal for *mandatory* second surgical opinions.

Discussions between MSMS and the Michigan Department of Social Services regarding a second surgical opinion program for Medicaid patients have consistently been based on a voluntary rather than mandatory approach.

MSMS believes that the recent development of voluntary second surgical opinions in Michigan, both by private insurers and by Medicaid, should be allowed to develop without the imposition of a requirement that would mandate a second opinion as a condition of reimbursement.

MSMS recommends that the second opinion programs currently in existence in Michigan should be the subject of intensive study to determine the actual costs and benefits of second opinions. Such research studies would appear to be a logical project for inclusion in the state health plan.

PROPOSED POLICY B5-5

By 1983 there should be a ten percent reduction in the rate of surgery for elective procedures in the state.

RECOMMENDED ACTIONS

B5-5.1: **To encourage patients to seek a second opinion prior to hospital admission for selected elective procedures, Blue Cross and Blue Shield of Michigan, insurers, and the Medicaid program should adopt policies that would make a second consultation a condition for reimbursement of designated procedures.**

B5-5.2: **State legislation should be enacted requiring the Medicaid program and all hospital insurance and service plans sold in the state which cover surgery to pay for a second opinion for selected elective procedures.**

B5-5.3: **The Michigan State Medical Society, the Michigan Association of Osteopathic Physicians and Surgeons, Blue Cross and Blue Shield of Michigan, and the Michigan Department of Social Services should establish a committee to select the elective procedures for which a second opinion will be required as a condition for reimbursement.**

PROPOSED POLICY B5-7

By 1983 a reimbursement mechanism or mechanisms for physicians should have been developed which will provide direct financial incentives for physicians to contain health care costs.

RECOMMENDED ACTIONS

B5-7.1: **The governor should appoint a special commission to study the desirability and feasibility of a reimbursement mechanism for physicians which would provide strong incentives for physicians to contain total health care costs. If such a system is found feasible and desirable, the commission should prepare a proposal for physician reimbursement. The study should include consideration of a rate-setting mechanism which embodies the following principles: a) performance standards for rates of increase of per capita health care costs (the sum of the costs of physician, hospital, x-ray, laboratory, and ancillary services) should be established for regions of the state; b) physicians' fees for a region should be left unregulated so long as the performance standards for the region are met; and c) the rate-setting mechanism should be activated in a region only if the performance standards are not met.**

Health care costs — Physician reimbursement commission

The Michigan State Medical Society has no objection to the creation of a governor's commission to study reimbursement mechanisms for physicians which would provide financial incentives to contain health care costs.

However, MSMS would like to point out that the preliminary state health plan contains three separate proposed policies and related recommendations to alter physician reimbursement mechanisms. B5-7 calls for a reimbursement mechanism which would provide incentives to contain health care costs; B2(A)-3 calls for another which would provide incentives regarding physician choice of specialty; and B2(B)-4 calls for yet another to provide incentives regarding physician choice of geographic location.

Additionally, the reimbursement mechanism called for in B5-7 (incentives to control health care costs) is to be a product of a special governor's commission while the mechanisms of B2(A)-3 (specialty) and B2(B)-4 (location) are under the auspices of the Office of Health and Medical Affairs.

MSMS believes that a truly integrated state health plan should avoid separate recommendations which are at the same time both a duplication and a fragmentation of effort.

MSMS supports the rationale for a special governor-appointed commission to undertake a task of studying physician reimbursement mechanisms rather than the Office of Health and Medical Affairs. As stated by OHMA staff in the narrative for B5-7, "The recommendation for a special governor-appointed commission is based on the expectation that such a commission of high-level people, including prominent representatives of the medical profession, would have such stature that its recommendations would have to be given serious consideration and could be rejected only with difficulty."

Therefore, MSMS would recommend that the Statewide Health Coordinating Council given serious consideration to expanding the task of the governor's special commission on physician reimbursement called for in B5-7 to include the issues of physician choice of specialty and geographic location.

Specifically, MSMS would recommend changing the current wording of the proposed policy B5-7 to read: "By 1983 efforts should be underway to develop a reimbursement mechanism or mechanisms for physicians which would provide financial incentives for physicians to contain health care costs, to influence physician choice of specialty and to influence physician choice of geographic location."

The recommended action should subequently be altered to include the additional two issues. In addition, the current wording of the recommended action presupposes the results of the commission's deliberations. The commission may legitimately decide to consider rate-setting as only one of the many alternatives for consideration, but MSMS believes that the scope of the study should be determined by the commission.

Therefore, MSMS would recommend that the recommended action conclude at the end of the first sentence, as amended by the new issues, thus reading: "The governor should appoint a special commission to study the desirability and feasibility of a reimbursement mechanism for physicians which would provide strong incentives for physicians to contain total health care costs, which would influence physician choice of specialty and which would influence physician choice of geographic location."

Health Care Costs — Physician Knowledge of Medical Costs

The Michigan State Medical Society has no initial objection to either the proposed policy or recommended action.

MSMS agrees that both medical students and practicing physicians should be exposed to information on health care costs.

An OHMA alternative has been proposed which states:

> To encourage sensitivity among practicing professionals to the need to contain costs, the state societies should take responsibility for organizing continuing education courses. In preparing the courses, the societies should consult with medical schools, schools of public health, health planning agencies, and other appropriate organizations.

It needs to be noted that the Michigan Board of Medicine (previously the Medical Practice Board) has informed MSMS that cost containment educational activities are not applicable under the present Medical Practice Act.

The September 15 correspondence correctly points out that the law requires physicians to attend continuing education courses or programs approved by the board totaling not less than 150 hours "in subjects related to the practice of medicine including medical ethics and designed to further educate licensees."

This information was received after MSMS scheduled programs on cost containment for the 1978 Annual Scientific Meeting, November 7-9.

MSMS would propose that the original recommended action and the alternative be included in the state health plan in addition to the following new recommended action:

> The Michigan Board of Medicine should adopt policies or regulations, or if necessary, request legislation, which would enable physicians to receive continuing medical education credit for attending courses or programs dealing with the economics of the health care system.

MSMS is pleased to note that community medicine courses have developed which include content in medical economics. Yet, it must be recognized that the nature of medical practice requires that what is best for the patient be given first priority and cost considerations second.

PROPOSED POLICY B5-1

By 1983 all graduates of allopathic, osteopathic, and dental schools should have knowledge of the economics of the health care delivery system, the nature of resource scarcity, and a variety of health care settings and an awareness of and sensitivity to the relative cost of therapeutic procedures.

RECOMMENDED ACTIONS

B5-1.1: **The medical and dental schools should continue their efforts to introduce into the curriculum elements which help to make students aware of the need for containing costs and sensitive to the way in which their behavior as providers affects costs. Where appropriate, the curriculum should also included information which helps students gain a broader understanding of the economics of the health care system. The Council of Deans and the Deans of the medical schools should establish formal mechanisms for sharing information on the approaches utilized and assessments of their effectiveness.**

Health Care Costs — Benefits

The Michigan State Medical Society questions whether the mandatory extension of the benefit package to family planning, prenatal care and well-baby care can truly be recommended based on the sole criterion of being cost-effective preventive services. While access to such services is certainly a worthy objective, provision of such services may prove prohibitive in terms of cost. MSMS believes these expanded benefits are, as of the present day, simply not cost accountable, and if recommended, must be done on some other basis than cost effectiveness.

PROPOSED POLICY B5-4

By 1983 all group health insurance policies and service plans which cover physician service outside the hospital should promote the use of cost-effective preventive services.

RECOMMENDED ACTIONS

B5-4.1: **State legislation should be enacted which requires that Blue Cross and Blue Shield of Michigan and insurance companies offering group coverage which includes physician services outside the hospital include as an integral part of that package (not as a rider) family planning, prenatal care, and well-baby care with appropriate limits on the number of visits.**

PROPOSED POLICY B2(A)-5

By 1980 statutory and regulatory obstacles to the utilization of primary care providers other than physicians should be eliminated. In addition, policies governing the reimbursement of such providers by third-party payers should be formulated and implemented.

RECOMMENDED ACTIONS

B2(A)-5-1: **The Office of Health and Medical Affairs should initiate and coordinate efforts to resolve legal and economic difficulties which hinder the utilization of primary care providers other than physicians.**

Health Personnel Resources — Non-Physician Providers

The Michigan State Medical Society believes that the primary focus of any proposed policy or recommended actions dealing with non-physician practitioners should be directed toward clearly defining their respective positions in the health care delivery system in Michigan.

The need for such determination is illustrated by the fact that although physician's assistants have been legally recognized in Michigan for several years, there are still no rules and regulations governing their appropriate utilization. Nurse practitioners, nurse midwives and nurse anesthetists have been authorized under the Public Health Code, yet the determination of their place in the health care delivery system needs careful study in order to avoid problems currently being experienced in writing the rules for the PAs.

Fundamental to the resolution of perceived legal and economic problems is the issue of whether non-physician practitioners are or should be independent or dependent practitioners. The proposed policy and recommended action *incorrectly* assume this critical issue has been resolved. Drafters of the preliminary state health plan have not been hesitant to deal with controversial issues up to this point and we see no reason to avoid the challenge presented with respect to non-physician practitioners. Therefore, MSMS would recommend that a proposed policy and recommended action be drafted calling for a clear definition of the position of non-physician practitioners in the health care delivery system, and based on such a determination, resolution of any attendant legal or economic difficulties.

Drafters of such a definition will have to ponder the value of the industrial model in contrast to the medical model when considering the utilization of lesser-trained personnel. Another factor to be considered is the loss of physician productivity to supervisory tasks rather than the direct provision of care. MSMS is prepared to offer its services if such a task is undertaken.

PROPOSED POLICY B2(A)-1

For the years 1978-1983, the number of first-year students enrolled annually in Michigan medical schools should not exceed 1977 levels (i.e., 720 students).

RECOMMENDED ACTIONS

B2(A)-1.1: **In formulating and acting upon the annual budgets of Michigan's medical schools, the Department of Management and Budget, the governor, and the legislature should provide support for no more than 720 students in each class.**

Health Personnel Resources — Medical School Enrollments

The Michigan Medical Schools Council of Deans recommends that for the years of 1979-1983, the number of first-year students enrolled annually in Michigan medical schools could realistically be set at 745.

The Council of Deans stated that this number is reflective of current projections for the next five years.

The Michigan State Medical Society would caution both the SHCC and the Council of Deans that projections for medical school enrollments must be made in light of Michigan's heavy dependence on foreign medical school graduates and federal legislation which will drastically reduce the number of FMGs allowed to practice in the country.

Existing projections of 720 or 745 first-year medical students may be totally unrealistic to meet Michigan's need for physicians if they are based on an additional resource (FMGs) which may no longer be available in the future.

This particular aspect of the state health plan needs to be carefully assessed each year.

Health care costs — PSROs

On October 20, the Plan and Policy Development Committee of the Statewide Health Coordinating Council considered the written proposed policy regarding PSROs and adopted the following alternative:

"By 1983 the PSRO Council should have established a mechanism for collecting and analyzing utilization data from all of the PSROs in the state to determine which PSRO areas demonstrate the best performance in terms of economizing on the utilization of health care resources (appropriate elements for analysis would include — by diagnosis or other appropriate unit measures — average length of stay, conditions of admissions, number and type of laboratory tests, etc.). The standard of best performance determined through such analysis should be made public information. PSROs should assess their own performance against these standards to determine the reasons for the difference in utilization and should either be able to justify different standards in terms of differences in the medical needs of the population being served or should alter their standards."

MSMS would support the alternative proposed by the Plan and Policy Committee.

MSMS is opposed to the recommended action as it is written here, but understands an alternative is being developed which is consistent with the new proposed policy.

MSMS recommends that the alternative include quality performance analysis as well as utilization and cost control. A serious challenge to the PSRO Council will be to identify criteria to determine appropriate quality performance outcome measures.

PROPOSED POLICY B5(AI)-2

By 1983 the membership of utilization review mechanisms (such as professional standards review organizations) should include consumers, other health professionals, and physicians who are totally unconnected with hospitals and the physicians being reviewed; specifically, physicians from outside the region should be members of the review committees.

RECOMMENDED ACTIONS

B5(AI)-2.1: **The federal government should amend Professional Standard Review Organizations statutes and/or regulation to permit inclusion of additional membership on professional standard review organizations committees as specified in Proposed Policy B5(AI)-2.**

Financial Barriers to Care — Acceptance of Medicaid Patients

The Michigan State Medical Society does not believe the need for such a proposed policy or recommended action has been demonstrated, particularly in terms of physician participation in the Michigan Medicaid Program.

The discussion/rationale provided for the proposed policy and recommended action are conspiciously devoid of any supporting data to demonstrate that Medicaid patients are being discriminated against and are unable to obtain medical care from physicians in Michigan.

On the contrary, physician participation in the Michigan Medicaid Program has consistently been higher than levels experienced by most of the other states.

Representatives of the Michigan State Medical Society are frequently invited to participate in national conferences along with representatives of the Michigan Department of Social Services as an illustration of successful partnership between state government and physicians in the delivery of medical care to Medicaid patients.

To recommend enactment of legislation making it unlawful for physicians to refuse Medicaid patients when the need for such drastic action does not exist is frankly irresponsible. MSMS strongly recommends that both the proposed policy and recommended action be deleted from the state health plan because to coerce either the patient or the physician into a relationship other than that of their own choosing can only be detrimental to quality medical care.

PROPOSED POLICY B7-1

By 1983 one hundred percent of physicians and dentists in direct patient care should accept Medicaid patients.

RECOMMENDED ACTIONS

B7-1-1: **State legislation should be enacted which would make it unlawful for providers of health care services to discriminate against any individual seeking care solely on the basis of the source of reimbursement so long as the services which the person seeks are reimbursable services.**

PROPOSED POLICY B5-2

By 1983 all consumers should have access to information on the cost and availability of physicians' and dentists' services within their region.

RECOMMENDED ACTIONS

B5-2.1: **County-based medical and dental societies should prepare regional directories of physicians and dentists which contain information such as price for rather well-defined procedures, length of time required to obtain an appointment, willingness to accept new patients (and Medicare and Medicaid patients), institutional affiliation, and board certification of specialties.**

Health Care Costs — Physician Directories

The Michigan State Medical Society is neutral on the issue of physician directories and leaves it to each individual physician's discretion whether to participate in such directories.

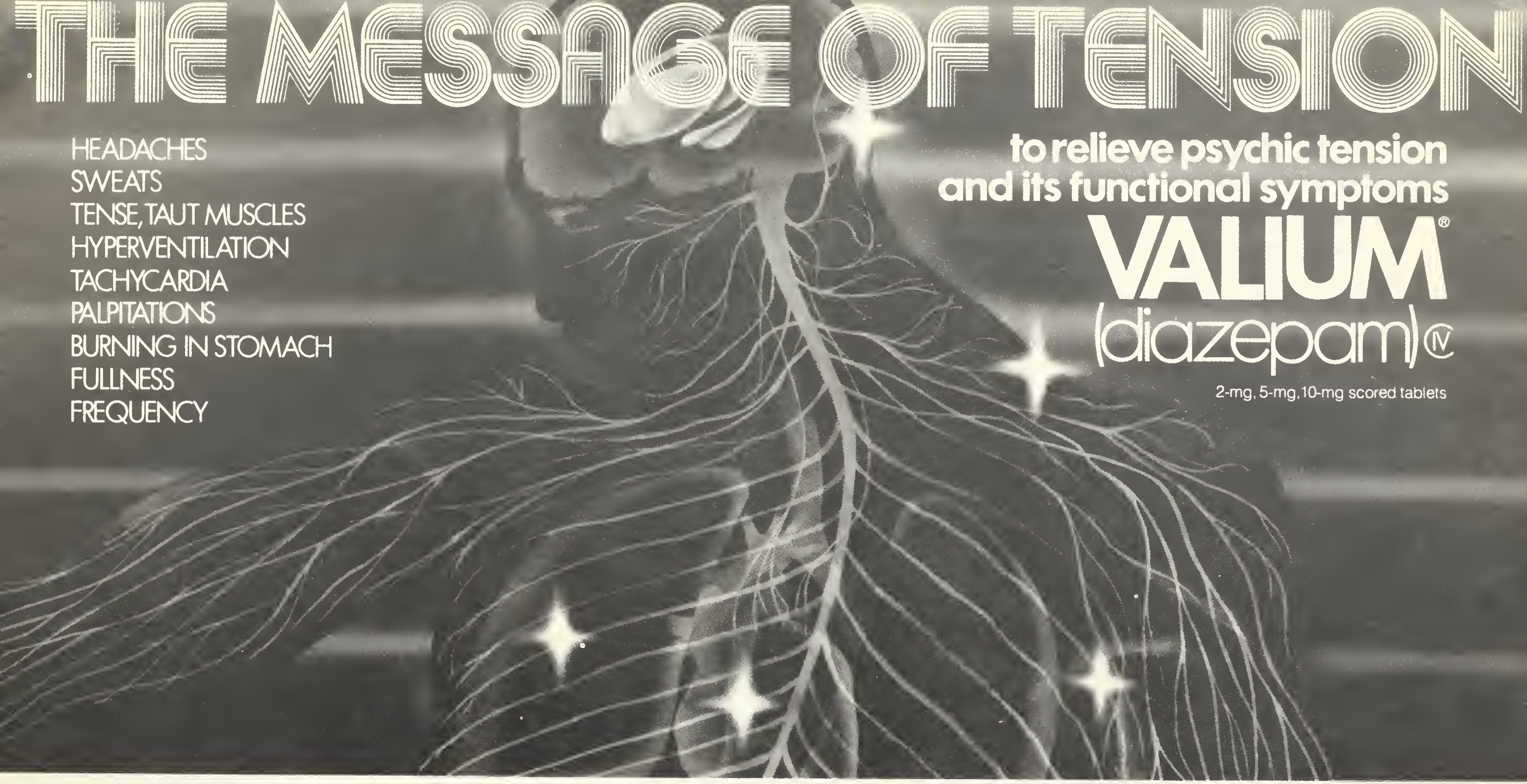
However, the individual decision whether to participate in a physician directory is far different than the preparation of such directories by any unit of organized medicine, particularly when the directories contain information such as price. The Federal Trade Commission has indicated that if an association as the Michigan State Medical Society were to prepare directories listing physician's fees there would be serious questions regarding restraint of trade and anti-trust violations.

Given the legal restraints, it would appear more logical for regional directories to be prepared by regional bodies such as the health systems agencies who have staff and funding. It would also seem likely that HSAs could undertake such an activity as part of the commitment to health education; apply for and receive funding to support the activity and distribute the directories to the public at no cost, thereby assuring access to the information by everyone.

MSMS recommends that if physician directories are to be prepared, the activity is more appropriate and feasible for health systems agencies to undertake. However, MSMS would caution HSAs to seek the cooperation and advice of component medical societies on such issues as editorialship and ethical tenets to assure quality responses from those physicians who participate in the directory listing.

Further, it must be recognized that like other professions and occupations, there is a high rate of mobility among practitioners and any directory would have to be updated at frequent intervals in order to have meaningful utility.

THE MESSAGE OF TENSION



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VALIUM® (diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient

Contraindicated: Known hypersensitivity to the drug Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy

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MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

FOR: Fred E. Patterson, MD, Ann Arbor
Member, MSMS Committee on State Legislation and Regulations, and radiologist

Doctor Patterson

"As a concerned MSMS member, I noted with interest the action of the 1978 MSMS House of Delegates strongly opposing certificate of need regulation for physicians' offices. I am wondering what success the state medical society has had since in opposing this regulation of medical practice."

The medical society was not successful in resisting encroachment on private physicians' offices by certificate of need, but it did achieve its absolute bottom line of protecting physicians and their patients. As the certificate of need section in the new Public Health Code was finally enacted, CON is required for major medical equipment purchases over $150,000 for hospitals, nursing homes, and almost all other facilities, including "tertiary health care facilities." The tertiary health care facility is described as one whose patients are referred by another physician, and which reports to the referring physician rather than the patient; in other words, outpatient radiology and pathology. As a practicing radiologist, I deeply resent the incursion on my practice by certificate of need. I doubt sincerely that our group can add an X-ray room now without the hassle of CON. But the message is larger than my own concerns: At the state level, for the time being, we have drawn a line on CON; at the federal level the Congress is still arguing about who and what medical facilities should be subject to CON. A large group of people want the CON program to include all private practice physicians' offices. We must all be wary and alert, and ready to join the battle next year in Washington, if necessary, to hold the line on certificate of need.

FOR: Richard W. Pomeroy, MD, Chairman
MSMS Committee on CME Accreditation

Doctor Pomeroy

"Our hospital is attempting now to keep CME records for staff physicians. We understand MSMS offers this service and would like to know more about it. What can you tell us?"

As chairman also of the CME department at E. W. Sparrow Hospital, Lansing, I am happy to tell you about MSMS CME record-keeping services. Sparrow, Hurley Medical Center in Flint, and St. Francis Hospital in Escanaba are three hospitals which now contract with MSMS to have records kept on the MSMS computers. MSMS keeps track of how many and which physicians attend meetings at those hospitals, and records their evaluations of the hospitals' courses. The MSMS form is being updated at present to provide better evaluation of hospital courses. This service is available to any interested hospital. Contact should be made with Wayne Burmeister at MSMS headquarters.

FOR: James C. Danforth, Jr., MD
Vice chairman, MSMS Delegation to the AMA

Doctor Danforth

"This is the time of year the AMA traditionally holds its clinical convention. Is one planned this winter, and where?"

The 32nd AMA Winter Scientific Meeting just concluded Dec. 7-10 in Las Vegas, but is not the same AMA Clinical Convention of previous years. The AMA has changed its schedule, which in the past included meetings in December and June of both the AMA House of Delegates and the scientific sessions. The AMA House continues to meet twice a year in those months, with the last two winter meetings having been in Chicago, in the interests of economy. There is just one scientific meeting now, in the winter. The AMA is concentrating on expanding regional CME programs, which are timely and to the point for the area's physicians.

Meetings

Calendar for AMA, MSMS, Auxiliary, Medical Assistants

Feb. 3-4 — Medical Assistants Mid-winter Seminar, Jackson, contact: Helen Schulte, MSMS headquarters.

Feb. 28-March 1 — MSMS Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Herb Auer, MSMS headquarters.

March 4 — Medical Assistants Board Meeting, MSMS headquarters, contact: Helen Schulte, MSMS headquarters.

April 10 — Legislative Day, MSMS Auxiliary, Olds Plaza Hotel, Lansing, contact: Helen Schulte, MSMS headquarters.

April 12 — MSMS Conference on Medical Aspects of Organized Athletics, Towsley Center, Ann Arbor, contact: Herb Auer, MSMS headquarters.

April 26-29 — Medical Assistants State Convention, Lansing, contact: Helen Schulte, MSMS headquarters.

May 4-6 — MSMS Auxiliary Annual Convention, Kalamazoo, contact: Helen Schulte, MSMS headquarters.

May 4-5-6 — MSMS House of Delegates, Kalamazoo Center Inn, Kalamazoo, contact: Dick Campau, MSMS headquarters.

MSMS headquarters used by many groups

November Meetings (held in the MSMS headquarters unless specified otherwise)

Reference Committee on Finance
Reference Committee on Legislative Policy
Committee on Publications
Work Group on MSMS Benefits
Steering Committee on Health Planning
Michigan Medical Assistants Post-Secondary Educators
Michigan Society of Respiratory Therapists
Ingham County Medical Assistants Board Meeting
Professional Standards Review Organization (PSRO)
Committee on Ways and Means
Task Force on Group Health Insurance Plan
Task Force on Medical Care Costs
AMA Program to Improve Health Care in Jails
Committee for CME Programming
Michigan Society of Internal Medicine
Committee on Service Benefits
Workshop for Component Society Leaders
Michigan Council of Specialty Societies
Seminar for CME Program Planners and Instructors

Perinatal Perspectives

1979 Michigan Conference
on Maternal and Perinatal Health

February 28

Patient Profiles — The Mother

Patient Profiles — The Baby

March 1

After the ICU — After the Nursery

Changing Concepts

Physicians/Nurses Mark Your Calendars:

February 28 — March 1
Hyatt Regency — Dearborn

Accept no substitute for your professional judgment

As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, substitution laws make it more difficult to exercise that right. In many states, unless you specifically direct pharmacists to dispense your brand-name prescription as written, they may be required by law to substitute another drug for your brand-name prescription.

This means that the ultimate drug selection is no longer yours; its source is left to the pharmacist's discretion. You will have forfeited your right to prescribe as you see fit. Preserve your rights. Specify that you will accept no substitution.

When you accept no substitutes...

- You ensure that your patient receives exactly that product you have specified on your prescription
- You choose the quality of the product dispensed to your patient
- You can exercise the right to select a product based upon its proven therapeutic performance and to select a manufacturer that stands behind its brand name or generic product
- You can support the kinds of research programs that are vital to new drug discovery and development
- You can help sustain important physician, pharmacist and patient education services supported by innovative, research-oriented firms

For complete information on the drug substitution law effective in your state, please consult your local Pfizer Representative.

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Pfizer **PHARMACEUTICALS**

New survey of Michigan's health personnel of major importance to future growth

By Charles Downs
Special to Michigan Medicine

Pre-survey Due in January

If you are a physician in Wayne, Oakland, Washtenaw or Kent counties, you have been selected to be a recipient of a pre-survey questionnaire from the Michigan Statewide Health Manpower Survey.

The reason for this distinction is that those four counties account for 85 to 90 percent of all Professional Corporations (PCs) in the state. What the surveyors want to know is which member of each PC will be responsible for completing the actual survey when it is conducted later in the year.

The questionnaire will ask if you belong to a PC, a partnership, or association or are employed by a hospital, government agency, industry or school.

At first blush, a pre-survey may seem like a bureaucratic overload, but it is designed to save work later for both surveyors and physicians. The "bottom line" is that surveying only one person in each organization means a saving of 5,000 to 6,000 questionnaires.

Counting doctors and other personnel in the state is a lot like counting white blood cells or a pulse rate or measuring blood pressure. There are many ways of quantifying a condition so that a diagnosis can be made and appropriate therapy initiated.

In the case of counting health personnel, the "patients" are the state itself and its various regions and communities. What is being looked at is the health of health care, specifically the needs for — or surpluses of — the special kinds of people that operate the delivery system.

Such data is essential so that the State Board of Education and the governing boards of community colleges and other educational institutions will know what kinds of academic programs to emphasize. Such figures are also of particular importance to the eight Health Service Areas that have been established in Michigan as the primary planners of health care in their respective regions.

Numbers and needs

Counting health personnel, however, is much more difficult than counting white blood cells. It means assessing the numbers needed as well as the numbers present of people holding more than 250 job titles ranging from receptionist to billing clerk to medical technician to hospital public relations director to physician.

The total number of such people in Michigan is in the hundreds of thousands and makes provision of health care one of the largest industries in the state.

Just ask Anne List. A retired Navy commander who has held several health administrative positions, Ms. List came to Lansing in 1975 to survey health personnel in the state for Michigan Regional Medical Programs.

Despite lack of time and money and the dismantling of RMPs by Congress, Ms. List managed to release a 1977 report, *Health Manpower in Michigan*, under the auspices of the Michigan Health Council.

Now she and Daniel H. Kruger, PhD, professor of labor and industrial relations at Michigan State University, plan a more complete, comprehensive document. They plan to acquire more information with proportionately fewer questionnaires than were used the first time around. Equipped with adequate time and money — two years and $185,838 from the Kellogg Foundation — Doctor Kruger and Ms. List plan to acquire more information with proportionately fewer questionnaires than were used the first time around. (Doctor Kruger is chairing the 25-member survey executive committee.)

More comprehensive survey

This time, Ms. List plans to avoid surveying doctors directly and instead to survey, whenever appropriate, the employers of physicians, including PCs. In order to reach the appropriate employers, Ms. List will make a pre-survey in January to determine which doctors belong to which PCs and which member of each PC is to be the respondent for the survey itself.

The importance of physicians complying with this comprehensive survey is emphasized by John H. Anthony, manager, MSMS Department of Economics, Negotiations and Finance.

"This survey will allow health professionals and planners to measure the actual numbers of people in the field against perceived and assessed needs for people," he says.

"Colleges, universities and other training centers for health care personnel then will be able to plan their production of people to meet those needs."

MSMS encourages all physicians to comply with the survey, which is the most comprehensive attempt, to date, to obtain this type of information in Michigan.

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- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1 For the relief of symptoms associated with cerebral vascular insufficiency.
2 In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral 10 to 20 mg., three or four times daily. Intramuscular. 5 to 10 mg (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia

Intravenous administration should not be given because of increased likelihood of side effects

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg intramuscularly at suitable intervals may be employed

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose. Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose, Injection, 10 mg. per 2 ml ampul, box of six 2 ml. ampuls

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20-mg tablets

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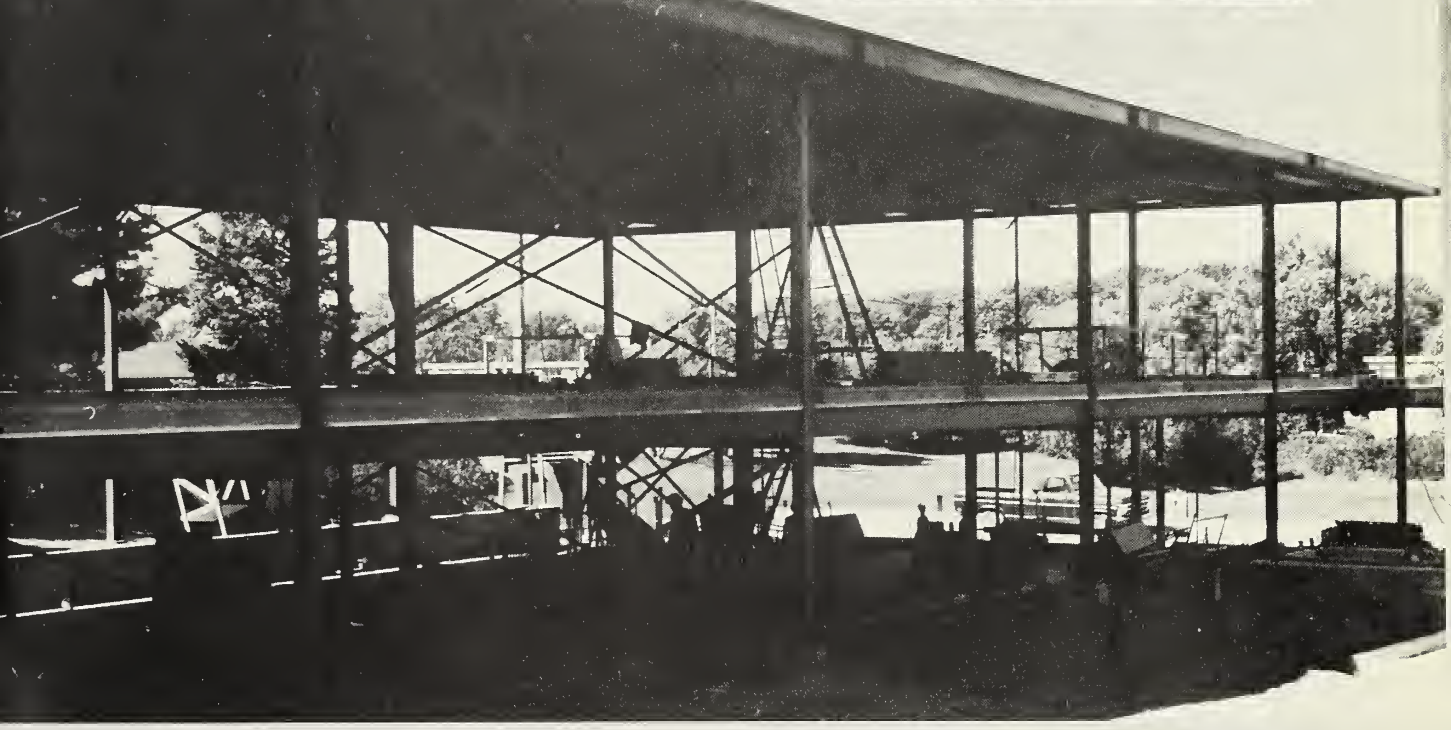
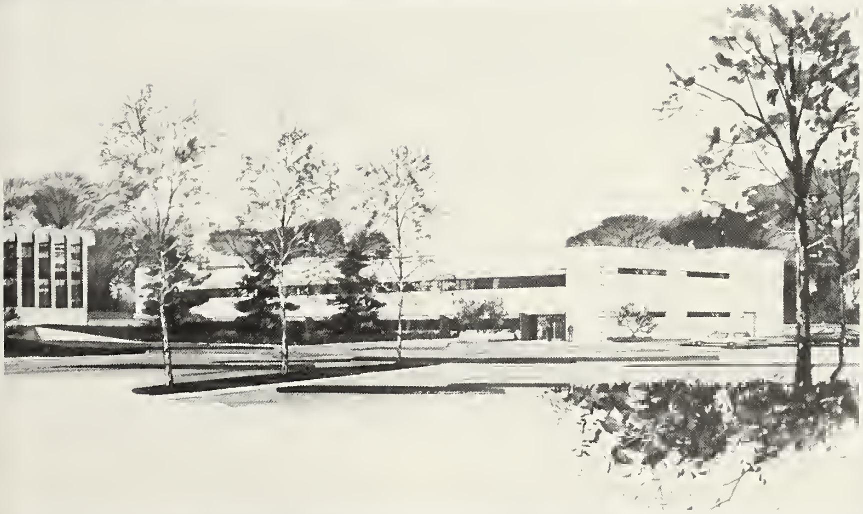
A workman uses an air wrench to tighten nuts on anchor bolts holding the steel girder framework of the new MSMS Stockwell Building. This stage was reached in mid-August following clearing, excavation, form building and foundation pouring. Within two or three days of setting the uprights, . . .



. . . the skeleton of the new building looked like this. As this issue goes to press, work is progressing on the enclosing of the building. Construction continues . . .

Progress report: MSMS headquarters addition goes up

(See detailed report next page.)



. . . and when it's all finished, the Cyrus Stockwell Building will look like this architect's drawing. Trees and shrubs have been planted in the parking lot recesses, and present and new parking lots resurfaced. The balance of the landscaping will be completed in the Spring. The Michigan Physicians Mutual Liability Insurance Company will lease the entire second floor of the new building with some MSMS offices and functions and additional lease space occupying the first floor.

Growth of MSMS services reason for Stockwell building

By John R. Ylvisaker, MD
Pontiac

Quietly, without much fanfare, a new demonstration of the expanding services and financial strength of MSMS is taking form on headquarters property. The Stockwell Building, named after Cyrus M. Stockwell, MD, of Port Huron, first president of MSMS, is under construction with a target date for occupancy of March 1, 1979. On completion it will represent 23,000 square feet of gross space, 17,000 square feet of net space, and will have cost approximately $1,200,000.

Two questions come in quick succession to any MSMS member who may not have been directly involved in the planning or decision-making:

Two questions

Why is the new office facility being built?

How is the Society managing the construction?

During the years of MSMS asset management, the Board of Managers has been continuously conscious of the Society's progressive growth and of its probable need for future workspace to service its members.

In 1971, adjacent land was bought as an investment of the Capital Reserve Fund at a cost of $33,000. In 1975, space needs were evaluated and preliminary site plans prepared at a cost of $5,000. Construction plans were postponed, however, because of the effect of the 1974-75 economy on Society funds and the lack of demand for the amount of space dictated by economies of scale.

By late 1977, Michigan Physicians Mutual Liability Co. (MPMLC) became a reality. Combined space needs of MPMLC and MSMS, both present and future, made the construction of a new office facility a realistic goal.

The Board of Managers with the approval of The Council proceeded with necessary studies to determine size, location, cost, financing, and general feasibility. The House Ways and Means Committee reviewed this information and approved the planned project with the approval of The Council and the House of Delegates in the spring of 1978. The Board of Managers proceeded with the selection of an architect, O'Dell, Hewlett and Luckenbach, and a construction management firm, the Christman Company.

Design, location and size of the building were major concerns. The exquisite architectural lines of the Headquarters Building have made it an East Lansing landmark. To avoid any detraction from this beauty, the new annex was purposely placed well back from the Saginaw Street facade on the west end of the property. Simple, flowing horizontal lines were designed for the new building to complement and enhance the Headquarters Building and to establish a quiet elegance for the Stockwell Building.

Building size was carefully planned to give balance to the building relationships, to allow for adequate parking and site beautification, to accommodate the present space need of MPMLC (10,000 square feet) and of MSMS (1,500 square feet) as well as to provide additional space for growth.

Financing the building

Normally, financing a major project such as the Stockwell Building would impose a substantial burden on the membership, calling for an assessment or dues increase. However, the MSMS asset management program has developed adequate resources to cope with major expenditures. Just as there were funds available to launch MPMLC ($200,000, now repaid), support of the new building could be mobilized from the equity in the present Headquarters Building, the increased value of the additional land, the net worth (over $1,700,000) of the Society and its positive cash flow.

A new mortgage for up to $1,600,000 was arranged with Michigan National Bank, incorporating both buildings, at favorable rates of 8¾ percent. MSMS indebtedness will be paid for by rental of space to MPMLC and to other carefully selected tenants.

Reasons for building

The answers to the first question, "Why build?" are more simple.

First, the advantage of MPMLC locating adjacent to the Headquarters Building is substantial for both organizations. They serve essentially the same membership, share common concerns for the continued viability and strength of the medical profession, often share common participants, and benefit from common information more easily developed and shared with working proximity.

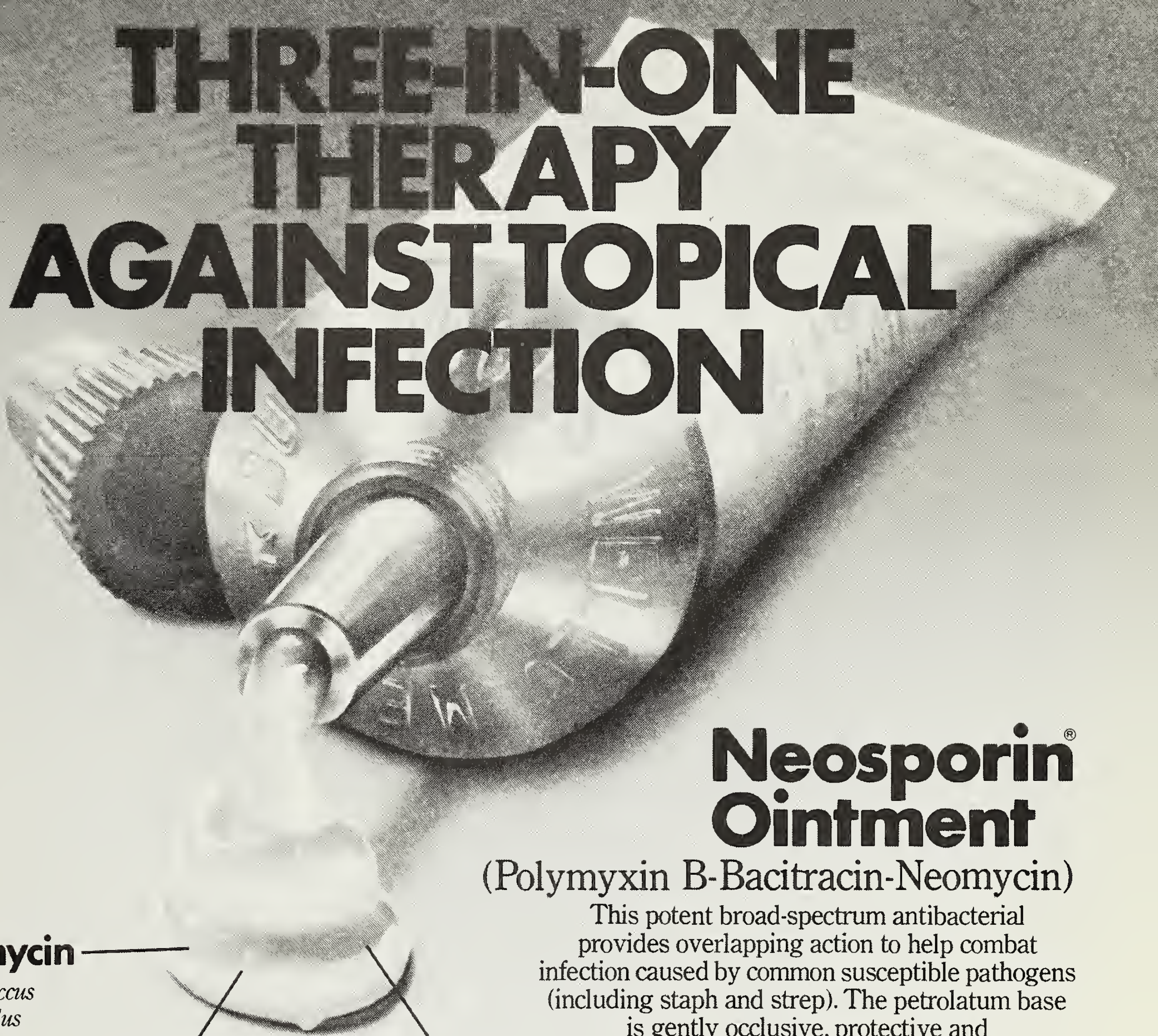
Secondly, MSMS has already outgrown its present quarters and would have shortly required off-site rental space. Additionally, there was the factor of the continued growth and complexity of Society needs.

Thirdly, rising costs and inflation made construction more palatable and manageable now than in the future. The added factor of a strong rental market was felt to promise assistance in amortizing the mortgage.

Lastly, the advantage of having reserve space to house related organizations was considered desirable as exemplified by the case of MPMLC.

Stop by and join the sidewalk superintendents if you have a chance. We hope you'll approve your new possession.

Doctor Ylvisaker is MSMS treasurer.



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Staphylococcus	*Staphylococcus*	*Pseudomonas*
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Klebsiella	*Streptococcus*	*Klebsiella*
Aerobacter	*Pneumococcus*	*Aerobacter*
Escherichia		*Escherichia*
Proteus		
Corynebacterium		
Streptococcus		
Pneumococcus		

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

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(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Letters

"The question not one of money or legality . . ."

I have before me a copy of your Sept. 18 *Medigram* and have read with interest your paragraph entitled "Medicaid Payments for Abortion, Autumn Battle for Legislature." As a member of the Michigan State Medical Society, I take exception to the last sentence in which you state, "MSMS is working to support Governor Milliken's position that Medicaid patients would be subject to discrimination of the anti-abortion language." You certainly do not speak for me in making such a statement.

Governor Milliken has repeatedly made the statement that benefits available to the affluent should also be made to the poor. Reference has frequently also been made to the fact that the Supreme Court has made elective abortions legal. The question is not one of money or legality in this difficult issue, but of the rightness or wrongness of the act.

I happen to be one of those physicians who believes that the unborn has equal rights to protection under the law as does the mother; and I, therefore, am disappointed that you would take a public position on this issue when certainly you know that physicians are divided on it and that supporting Governor Milliken's position is hardly the proper role of the Michigan State Medical Society.

Robert B. White, M.D.
Northern Michigan University
Marquette

Editor's Note: Doctor White is correct in his contention that the philosophical issue of the rightness or wrongness of abortions is not addressed by MSMS policy. The MSMS House of Delegates' established policy is that Medicaid clients should have access to all medical services available to persons in the private sector. The House did not feel a precedent should be set in denying Medicaid payment for any medical care, and supported the current practice of state funding of abortions for Medicaid patients in its Resolution #34 of 1978.

"We, too, are concerned with the confidentiality of the sensitive data. . ."

We are pleased with the October 1978 *Michigan Medicine* article on the Michigan Health Data Corporation and the support that Daniel Fall, MD, has given to this consortium.

We too are, of course, concerned with the confidentiality of the sensitive data collected by the Michigan Health Data Corporation and appreciate the assistance that Doctor Fall, as a Board member, is able to give to the Corporation in maintaining confidentiality.

Just for the record, there are 14 organizations with representatives on the MHDC Board, rather than 15. The Michigan Department of Public Health has elected to participate as an observer only. Thank you again for the excellent article and the support of the Michigan State Medical Society.

Larry W. Brown
Executive Director
Michigan Health Data Corporation

"The MPH can provide basic statistical information. . ."

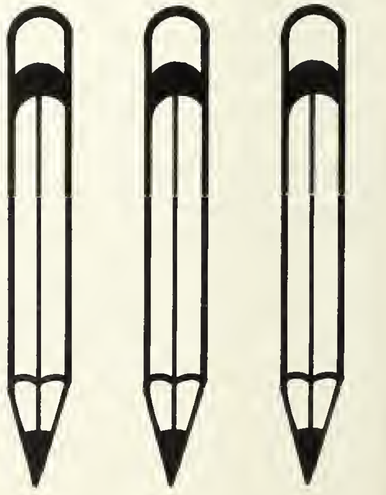
Thank you for sending the October 1978 issue of Michigan Medicine, containing the feature on sources of information. We are pleased that the Michigan Cooperative Health Information System's data on MD's have been useful to you.

I would like you and your members to know that, through MCHIS, the Department of Public Health can provide basic statistical information on the location, characteristics, education, and professional employment of 14 licensed health professions (no individually-identified data are released). Basic statistics are also available on inpatient health facilities, covering location, size, services, and staffing patterns. Data can be requested by writing to my office (Office of Statistics Research and Evaluation, Department of Public Health, telephone (517) 373-9000).

Data on births, deaths and other vital statistics are provided through the Office of Vital and Health Statistics (telephone (517) 373-1390).

In the future, we hope to expand both the scope of coverage of our health information system, and our services and consultation to users of data throughout the state.

Rita Zemach, PhD, Chief
Office of Statistics
Research and Evaluation
Michigan Department of
Public Health



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'A day in the life' — MSMS staff fields variety of requests, suggestions

By Katie Brewbaker
MSMS staff

Have you some unpaid accounts on your books you're convinced you'll never collect? Don't despair. We may have just the answer for you, if you're willing to make a small investment for printing some new statements.

A physician in Belfast, Ireland got instant results from the statement he sent to his patient which read as follows:

Dr. Douglas B. Boyd
presents his compliments to
Mrs. Lenie Sikkema
and begs to intimate that his fee
for professional services
is £ 6.75

The billing was dated March 27 and marked "paid" March 30! How's that for prompt payment?

This is just an example of some of the "unusual" printed material and letters, received at your MSMS headquarters.

Some of it is a joy, like the letter from the gentleman who wrote, "We have recently had an opportunity to admire the gentle approach of some of your posted signs quoting 'THANK YOU FOR NOT SMOKING.' Upon close examination we noticed your generous offer to furnish additional signs. We would be more than pleased to receive a dozen for use in various rooms of our church. Thank you for your service."

That letter contrasts vividly with the notation scrawled across a questionnaire returned to the office which shouted the following threat to a request for the respondent's Social Security number: "You just try and get it. I was raised in Hell's Kitchen and I dare you to make me do it."

Needless to say, the man still has sole possession of his Social Security number. MSMS was not about to take him on.

Others who write volunteer to give information. Recently a woman unselfishly offered to share, for the benefit of all and at no financial gain to herself, a unique emergency identification system she had devised for people with special medical problems such as diabetes, drug allergies, etc.

She had no quarrel with having this information on a bracelet or drivers license, but was worried about what would happen to the accident victim who didn't have their emergency identification on them when stricken. So, she suggested the use of tattoos.

For instance, a red dot tattooed behind the right ear might mean the person was a diabetic, a green dot behind the ear would signify some other malady, tiny pictures could be used to designate other conditions.

Now, if all emergency service personnel can just memorize the codes

Not all communications come in the mail. Many people prefer to express themselves over the phone.

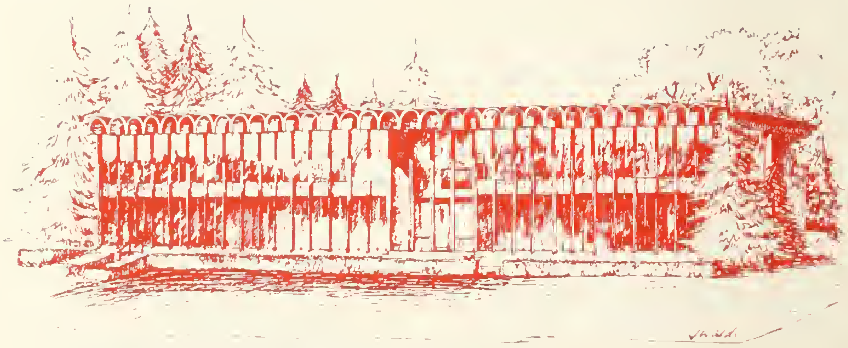
There was the young man who called to inquire if any of the medical schools in Michigan paid for cadavers — a question that in itself doesn't seem really that unusual or bizarre. But, further conversation revealed what he really wanted to know was if one of the schools would be interested in buying his body now, in advance!

There also was the woman who telephoned seeking information on a doctor who uses the "rubber band technique" for removing hemorrhoids. Supposedly this procedure works like this: the doctor ties off each hemorrhoid with a rubber band. After a period of time the hemorrhoid, strangled from its blood supply, automatically falls off.

Does anyone out there practice this technique?

And, finally, how would you respond to this recent call? A man phoned to register a complaint. He explained his wife had just had an abortion and it didn't work. Why, even before he could get her home they had to stop in Grand Rapids and have another one!

And, so goes the day at MSMS headquarters.



DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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1979 Maternal Health Conference Feb. 28-March 1 in Dearborn

By Katie Brewbaker, MSMS staff

"Perinatal Perspectives" is the theme for the 1979 Michigan Conference on Maternal and Perinatal Health scheduled at the Hyatt Regency Dearborn, Feb. 28-March 1.

Under the co-chairmanship of Bruce A. Work, Jr., MD, Ann Arbor, and John W. Hallitt, MD, Flint, the Conference Planning Committee is developing an innovative program of Category I courses.

The two-day meeting will be divided into four segments. Wednesday will be devoted to two courses using case histories as the "seed" for in-depth discussions, with identification of the high risk obstetrical patient being discussed during the morning session and the high risk pediatric patient the afternoon topic.

An outstanding authority will open each segment of the Wednesday programs with a comprehensive 45-minute presentation on the subject to be covered. After the groundwork is laid by the opening speaker, three different case histories relating to the subject will be presented by a panel of experts. Each panelist will introduce a case history and then it will be discussed by the presenter, the other panelists, and the featured main speaker. The case histories will be sent to all registrants in advance so they may familiarize themselves with the cases prior to the meeting.

Thursday morning will be devoted to discussions of back transfer, infant bonding, the high risk family, infant mental health, and other timely topics. The afternoon program on Thursday will feature a discussion on the facts and fantasies of home delivery, a speaker from HEW is being sought, and an outstanding medical writer (Harry Schwartz, of the *New York Times* has been invited) will address the registrants on "what the public perceives and wants in maternal and pediatric care."

Co-sponsoring the Conference with the Michigan State Medical Society are the Michigan Academy of Family Physicians; Michigan Chapter, American Academy of Pediatrics; Michigan Department of Public Health; Michigan Nurses Association; Michigan Section, American College of Obstetricians & Gynecologists; Michigan Section, Nurses Association, American College of Obstetricians & Gynecologists, District V; Michigan Society of Obstetricians and Gynecologists; Perinatal Association of Michigan, and Wayne County Medical Society.

Component, specialty leaders to learn MSMS media tips

The Task Force on Media Relations is arranging a special Workshop on Media-Press Relations for Feb. 1 at the MSMS headquarters in East Lansing. Beamed at component society and specialty organization leaders, this unique workshop will provide attendees with an opportunity to hone their skills in a news conference setting. Plans are being made for registrants to actually "field" questions before a live TV camera, with a playback to see how they did. In addition, instruction will be given on how to prepare and deliver a news statement and handouts and commentary will be made available giving helpful hints on the staging, timing, and location of news conferences.

Working under the aegis of its parent body, the Committee on Public Service, the Task Force is moving forward with arrangements for the workshop, and a mailing will be sent soon to interested parties. As physicians across the state are increasingly being asked to respond to media inquiries, this workshop will prove a valuable training session for those who work with the media.

Chairman of the Task Force on Media Relations is Robert D. Burton, MD, of Grand Rapids. MSMS members wishing more information on the workshop may contact Mert Scholten at the MSMS office (517) 337-1351.

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New CME rules and regs went into effect Nov. 3 — here are excerpts

Amended general rules and regulations are in effect governing the continuing medical education requirements for Michigan physicians in all six categories.

The new CME rules and regs were drafted by the Michigan Board of Medicine, approved by the legislature's Joint Administrative Rules Committee, signed by the governor and filed with the secretary of state.

They took effect Nov. 3 and are excerpted below for physicians' reference.

Category 1

Continuing medical activities including medical ethics with accredited sponsorship; tutorial experience; specialty board certification and recertification.

Rule 74. (1) The board shall continue to grant category 1 credit for those continuing medical education activities which met the standards adopted by the commission on continuing medical education of the Michigan State Medical Society on November 10, 1975, or the standards adopted by the house of delegates of the American Medical Association in June, 1970, as previously established by the rules of the board on continuing medical education.

(2) Continuing medical activities with accredited sponsorship are category 1 activities. The board approves the standards adopted by the committee on continuing medical education accreditation of the Michigan State Medical Society on April 1, 1978, in accrediting organizations and institutions offering continuing medical education programs, and the board may accept a maximum of 150 credit hours under category 1 for attendance at programs offered by organizations and institutions so accredited as credit towards the licensee's continuing medical education requirement if the programs are designed to further the medical education of licensees. The board may deny approval of programs offered by institutions and organizations approved by the Michigan State Medical Society whenever it appears to the board that the programs offered by those institutions or organizations fail to demonstrate compliance with the legislative intent to further educate licensees on subjects related to the practice of medicine.

(3) The board approves the standards adopted by the Liaison Committee on Continuing Medical Education on July 1, 1977, in accrediting organizations and institutions offering continuing medical education programs, and the board may accept a maximum of 150 credit hours for attendance at those programs offered by organizations and institutions so accredited as credit towards the licensee's continuing medical education requirement if the programs are designed to further the medical education of licensees. The board may deny approval of programs offered by institutions and organizations approved by the liaison committee on continuing medical education whenever it appears to the board that the programs offered by those institutions or organizations fail to demonstrate compliance with the legislative intent to further educate licensees on subjects related to the practice of medicine.

(4) The board approves and incorporates herein by reference the standards adopted on July 1, 1977, by the Liaison Committee on Continuing Medical Education in approving organizations and institutions offering continuing medical education programs. A maximum of 150 credit hours for attendance at continuing medical education programs sponsored by organizations or institutions which have not been accredited pursuant to subrules (1) or (2) or (3) may be accepted by the board as credit towards the licensee's continuing medical education requirement, but only if the sponsoring organization or institution first submits such information as the board determines may be necessary to establish that the sponsoring institution or organization is in conformity with the aforementioned standards, and only if the board thereafter approves the organization or institution.

(5) Tutorial experience is a category 1 activity. A maximum of 150 credit hours during the 3-year period may be earned for being tutored in a hospital or institute. Notwithstanding any additional requirement of these rules, the board will not give credit for being tutored unless information on the tutorial program and the qualifications of the tutor, as well as any other data requested by the board, is first submitted to the board to establish the quality of the tutorial program, and if the board approves the tutorial program before the commencement thereof.

(6) Specialty board certification and recertification are category 1 activities. A maximum of 50 credit hours may be earned for taking and passing a specialty board recertification or certification examination approved by the board. Credit may be earned only during the year in which the licensee is advised that he or she passed the certification or recertification examination.

Category 2

Continuing medical activities with nonaccredited sponsorship.

Rule 75. Category 2 activities consist of continuing medical activities with nonaccredited sponsorship. A maximum of 36 credit hours during the 3-year period may be earned by attendance at continuing medical education programs offered by organizations or institutions that are not approved under category 1 if the program is submitted to the board to establish the quality of the program, and if the board approves the program in accordance with rule 80.

Category 3

Tutoring medical physicians under category 1; teaching medical physicians; teaching the allied health services.

Rule 76. (1) Tutoring medical physicians under category 1 is a category 3 activity. A maximum of 48 credit hours in the 3-year period may be earned for tutoring medical physicians in a tutorial program approved by the board under rule 74(5).

(2) Teaching medical physicians or teaching the allied health services are category 3 activities. A maximum of 48 credit hours in the 3-year period may be earned for serving as an instructor of medical students, house staff, or other physicians or allied health professionals in a hospital or institute with a training program approved by the board, if the hospital or institute has approved the instruction. A maximum of 48 credit hours in the 3-year period may be similarly obtained in a hospital or institute that does not have a training program approved by the board if the sponsor of the program first submits such information as the board determines to be necessary to establish the quality of the instructional programs approved by that hospital or institute.

Category 4

Books, papers, publications, and exhibits.

Rule 77. (1) Category 4 activities comprise books, papers, publications, and exhibits. A maximum of 48 credit hours in the 3-year period may be earned under this category, with specific maximum credits indicated in the subcategories described below. Credit may be earned only during the year of presentation or publication.

(2) A maximum of 24 credit hours in the 3-year period may be earned for preparation and initial presentation of a scientific exhibit at a professional meeting.

(3) A maximum of 24 credit hours in the 3-year period may be earned for preparation and initial presentation of a formal original scientific paper before a professional meeting.

(4) A maximum of 24 credit hours in the 3-year period may be earned for preparation and initial publication of an original scientific article or paper, or a chapter in a book, or a portion of a chapter in a book, that is authored and published in a journal or other periodical publication listed in "Index Medicus," or that is published by a medical publisher recognized by the board.

Category 5

Nonsupervised education; self-assessment; self-instruction; participation on a hospital staff committee dealing with quality patient care or utilization review.

Rule 78. (1) Nonsupervised learning is a category 5 activity. A maximum of 36 credit hours in the 3-year period may be earned under this category, with specific maximum credit hours indicated under the subcategories described below. Credit may be earned only for the year in which the study, committee, or review activity occurred.

(2) Self-assessment is a category 5 activity. A maximum of 18 credit hours in the 3-year period may be earned for completion of a multimedia program if sufficient information regarding the program is approved by the board.

(3) Self-instruction is a category 5 activity. A maximum of 18 credit hours in the 3-year period may be earned for the independent reading of scientific journals listed in "Index Medicus."

(4) Participation on a hospital staff committee dealing with quality patient care or utilization review, or both, are category 5 activities. A maximum of 18 credit hours in the 3-year period may be earned for participation on a hospital staff committee dealing with quality patient care or utilization review.

Category 6

Full-time participation in a graduate training program.

Rule 79. Full-time participation in a graduate training program is a category 6 activity. A maximum of 50 credit hours per year may be earned for satisfactorily participating, in the 3 calendar years preceding the application for renewal, in a graduate training program in a hospital or institute approved by the board. A minimum of 5 months' participation per year is required for 50 hours of credit.

Statement of ownership, management and circulation of *Michigan Medicine*

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published three times per month, 36 issues, mailed at East Lansing, Michigan, and additional post offices in Ingham County for December 1, 1978.

1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

3. The publisher is the Michigan State Medical Society. The managing editor is Judith E. Marr, 120 West Saginaw Street, East Lansing, Michigan 48823; the executive editor is Herbert A. Auer, 120 West Saginaw Street, East Lansing, Michigan 48823.

4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

5. The known bondholders, mortgagees and other holders owning or holding one percent or more of total amount of bonds, mortgages, or other securities are: None.

6. A. The total number of copies printed averages 8,899 per issue with a single issue nearest to filing date accounting for 8,705 copies.

   B. Paid circulation 8,543 subscriptions by mail, these being the active members of the Michigan State Medical Society, and others who receive subscriptions.

   C. Sales to dealers, number none.

   D. Free distribution by mail carrier or other means: 282.

   E. Total number of copies distributed is 8,825.

I certify that the statements made by me above are correct and complete.

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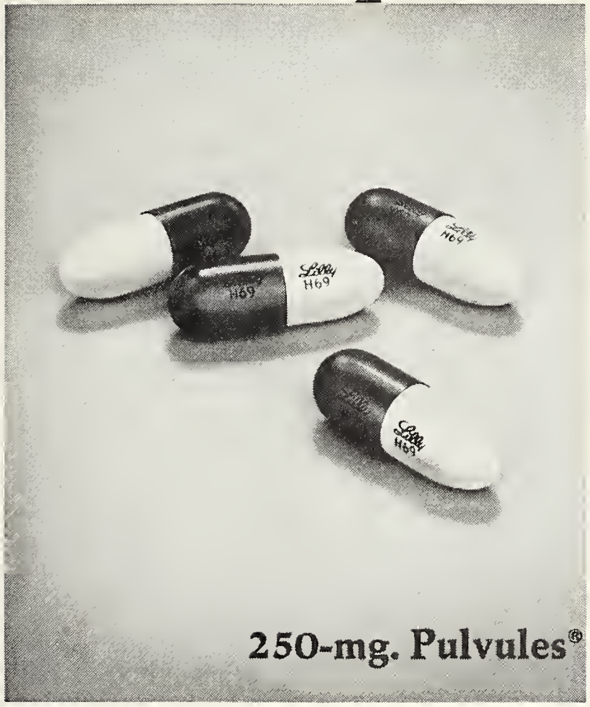

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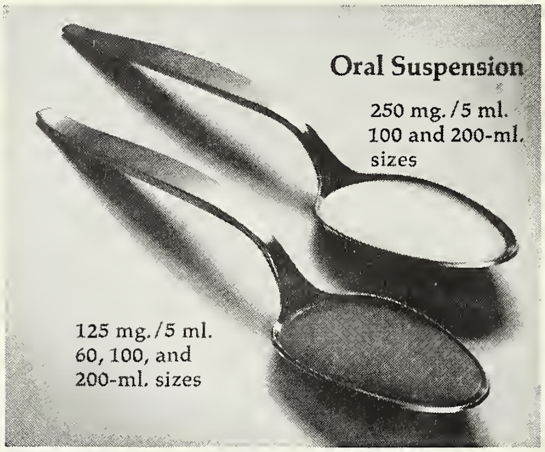

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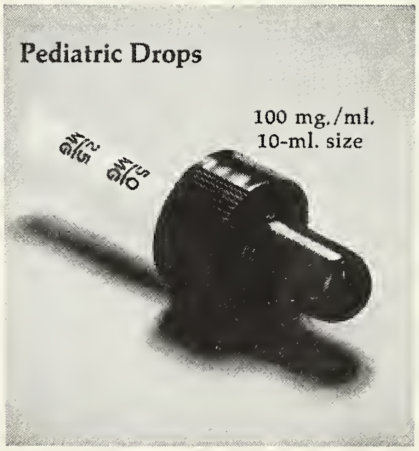

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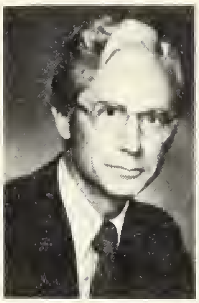
Views

The stakes are enormous — we need our strong AMA voice


Doctor Masters

By Brooker L. Masters, MD
Baldwin

As illogical as it seems, the political furor over a national health care system continues to occupy the public utterances of a number of important leaders. President Carter, Secretary Califano, a number of legislators, union leaders, consumer advocates — to name a few — continue to speak out for some form of nationalization.

One of Senator Kennedy's principal vehibles in his run for the presidential nomination is a forceful demand for national health care. Many of his statements seem almost paranoid on the subject. One would suspect that the man either should know better, or else senses the mood of the people better than most of us — and he feels this kind of demagoguery might well propel him into our nation's top job.

If all these efforts had some magical ability to improve our system, or make medical care more available to more people at less cost, then they should be vigorously supported. The facts are just the opposite.

Two important thoughts

As we in medicine survey the scene, two things need to be constantly kept in mind:

1) The socialization of our profession in all the other countries of the world began in just this same clamorous manner, and such a system has not made those countries "more healthy" nor made the quality of care higher; and

2) Whether we admit it or not, a great percentage of our population *would* like to see some form of nationalized health insurance. Industry and individuals alike are aware of the potential costs and the inevitable decline in quality of the care inherent in any nationalized system. But costs are already so high that many would like to shift the burden elsewhere, even to government. Somehow, they reason, the care will be delivered, and the financial burden would be shifted to the overall tax base. This sentiment is much more prevalent than any of us are willing to admit.

These are some of the nuances of this political harangue which goes on year after year, and just won't go away. It is a desperate struggle. For, if medicine ever does go under, considering the delicate balance of this debt-ridden, deficit financed, inflationary economy, it would seem only a matter of time until we would have a socialistic government in toto.

We have created a bureaucratic mess in this Americanized version of democracy, it is true, but it is a far cry better than any socialized proposal that might be substituted. So the stakes are enormous.

Strong national voice needed

All of the issues affecting the practice of medicine — quality, quantity, economic, and even availability — are being debated on a national basis. At no time have we needed a strong national voice more than now. That national voice has always been, and still is, the American Medical Association.

Sometimes called "conservative, staid, reactionary," the AMA is as vigorous as its members want it to be. That is why it is such a shame that only 45 percent of all physicians in the U.S. are members. It isn't just that the treasury needs that additional $250 dues payment from more active members; it is more that such a statistic indicates the degree of apathy of physicians and creates an incapacity of the AMA to speak as one voice for the entire profession.

It is high time our profession stands up to be counted. Those who are not members of the AMA are in default: they are allowing those who are paying their dues to carry the burden while they reap the benefits. Those who sit back and complain that the AMA does not represent them are being unfair if they don't get in and participate. We are just as illogical as the politicians if we do not band together and speak with a unified voice that truly represents the entire profession.

When I put down my stethoscope for the last time, I want to leave for my daughter, who is also a doctor, a profession with as much opportunity as I had when I entered it those many years ago. I know that only through a national voice can that be done in these 1970s.

I am proud to be a member of the American Medical Association. It really does work to keep this the greatest profession on earth.

Doctor Masters is a past MSMS president and is a member of the Michigan delegation to the AMA.

Take a close look at salaries of employees in your office

By R. Timothy Hogan
Ann Arbor

With expenses climbing and the option of periodically increasing fees diminishing, salaries loom large in a physician's overhead these days. In many professional practices, labor costs now account for between 30 percent and 40 percent of the cost of doing business.

The share of overhead allotted to salaries varies according to a doctor's specialty. Some specialists require more office help than others. Surveys performed by Black and Skaggs Associates, Inc. show that while a psychiatrist might spend as little as 10 percent of overhead for salaries, a general or family practitioner might spend as much as 38 percent. An obstetrician/gynecologist's outlay might be 33 percent for salaries as against an expenditure of 16 percent by a pediatrician or 15 percent by a dermatologist.

Surveys also reveal that incorporated physicians spend 25 percent or more on salaries than do physicians in partnerships and solo practices. The explanation is that medical groups tend to hire more employees and delegate more routine duties to them. But, in truth, incorporated physicians generally earn more than do their non-incorporated colleagues — anywhere from a few thousand dollars more to as much as $30,000 more, depending upon specialty and location. And while an unincorporated physician, such as a general surgeon, who does most of his work in hospitals might have overhead of only 32 percent of his gross earnings, large physician groups might have overhead of as much as 60 percent of gross earnings.

With salaries representing a sizable share of overhead, a physician who is spending considerably higher — or lower — percentages on salaries than are colleagues should take a closer look at the practice.

Salaries off average?

There's an outside chance there are too many employees on the payroll, and the doctor is spending too much for assistance. This is often self-defeating since capable assistants without enough to do soon get bored and move on to jobs with greater challenge.

When the reverse is true, and a physician doesn't hire enough help to keep the office running smoothly, additional problems develop. If the overworked employees don't quit, necessitating outlays to find, hire and train replacements, the office suffers. Paperwork doesn't get done, records pile up, bills don't get out on time, collections suffer. Tempers fray, mistakes tend to occur and the general harrassed atmosphere communicates readily to patients. Ultimately, though the physician may not recognize why, the deficiency shows up in reduced income.

Short on help?

Here are some signs that a medical office probably is short on help:

- Unanswered telephones.
- An overflowing reception room with patients waiting overly long to be seen.
- Pile-ups of medical and business records.
- A backlog of uncompleted insurance forms.
- Sloppy housekeeping.
- Too many overtime hours.
- A constantly rushed atmosphere.

When an office is short-staffed, a physician is well-advised to add help. A look at what currently is being spent for salaries may reveal it is possible to do so and still stay within the accepted range for this overhead expenditure.

There's another important factor that every physician must consider today when asking: "How many employees do I really need?" A doctor no longer can merely increase fees each time costs go up. And costs have been climbing rapidly along with inflation. Inflation shows no signs of tapering off in the near future. Yet there's widespread resistance in the nation to higher medical costs, among them doctors' fees.

The logical way for a physician to stay ahead financially is to increase productivity. That means seeing more patients even if the present schedule appears already strained at the seams. Increasing productivity means increasing overhead — sometimes for more office space and equipment, but more often for additional help to handle a bigger patient volume. It's the old "spend money to make money" concept.

Another employee worthwhile?

Is it worth it to hire another employee? Let's say a physician thinks he or she could see 20 more patients a week. The employees already are overworked. So the MD does some rough calculating, figuring to have to pay a competent assistant $8,000. The net income per patient visit is $14. Assuming practice five days a week 48 weeks of the year, seeing one more patient each day would bring in $3,360 a year — not enough to justify the new employee's salary. By seeing three more patients a day, the doctor will produce $10,080 in additional revenue, pay the new employee and come out $2,080 ahead. The real gains come at this point. If the doctor actually can work in the 20 more patients a week maximum with the new assistant, he or she will add $13,440 to the gross for an additional profit of $5,440 after paying the salary of the

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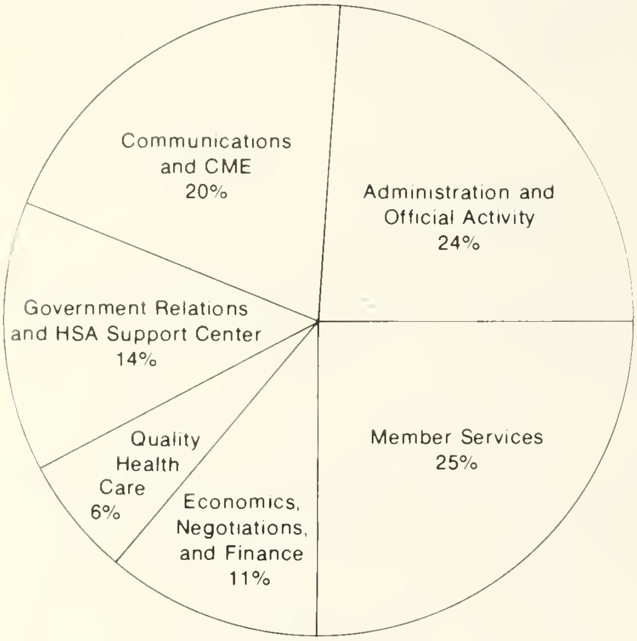
Mr. Hogan is management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

The proportion of members' dues allocated to MSMS activities

Here's a pie chart to help MSMS members better understand what proportion of their dues are used to support what MSMS activities. Salaries of staff personnel are included in the "wedge" according to the department they're assigned to. Percentages also are indicated.



BUSINESS/*continued*

new employee. And from here on, each additional patient seen adds to the profit.

Increasing productivity may require a physician to rethink some past methods of practicing. To devote more productive time to seeing patients, the doctor may have to be willing to delegate more of the routine chores to the new assistant and to other employees. For some physicians, that's not an easy change.

Is the physician still giving all injections? Could this responsibility be assigned to a competent nurse? Can assistants take basic patient histories, height and weight data, and perhaps give some of the simple instructions to patients that the physician previously was in the habit of giving?

The physician who can delegate — who doesn't have to do everything — will be able to benefit from hiring a competent additional assistant. The results will follow in greater patient volume, improved efficiency in the office, and in the financial return at the end of the year.

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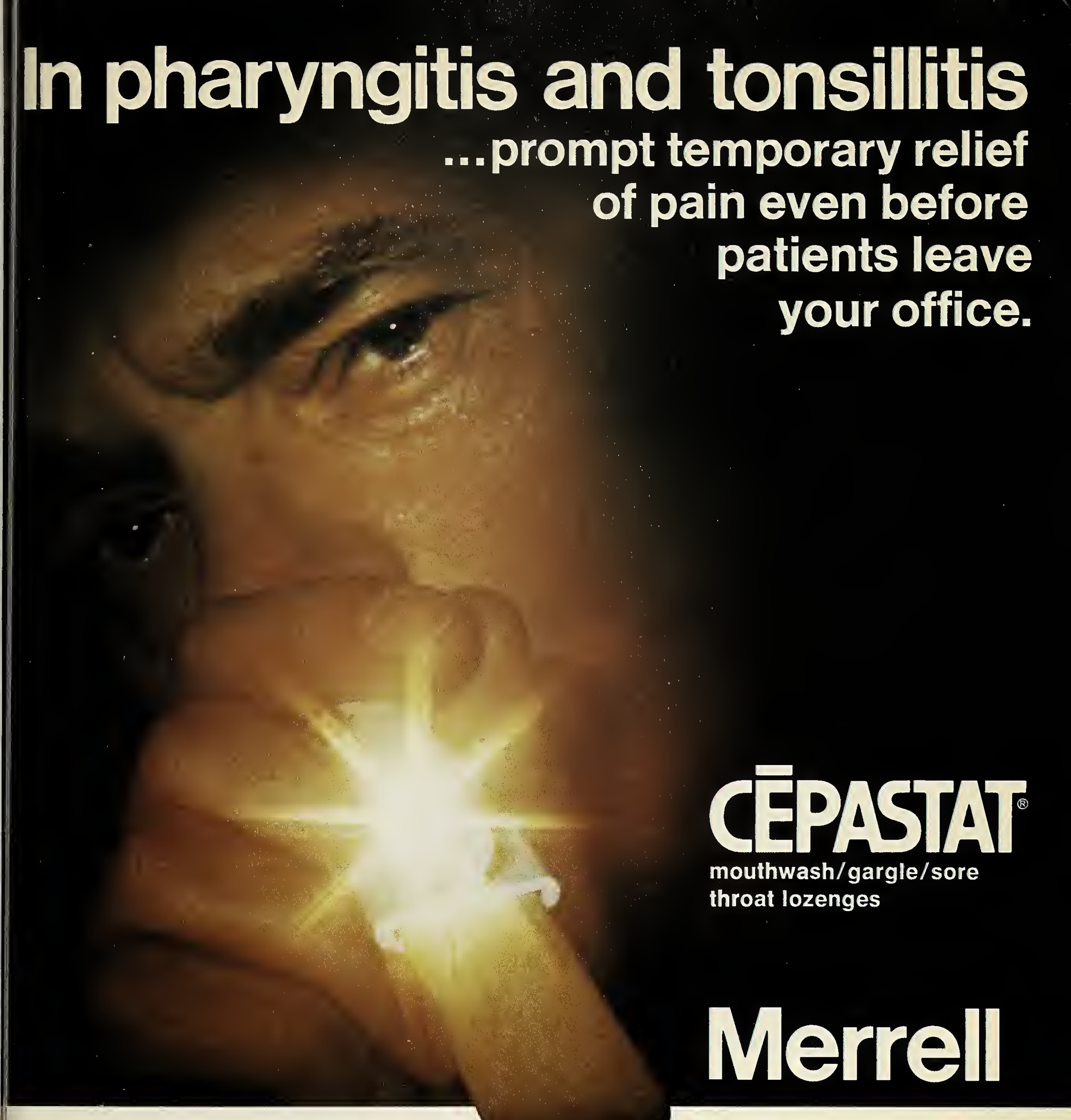

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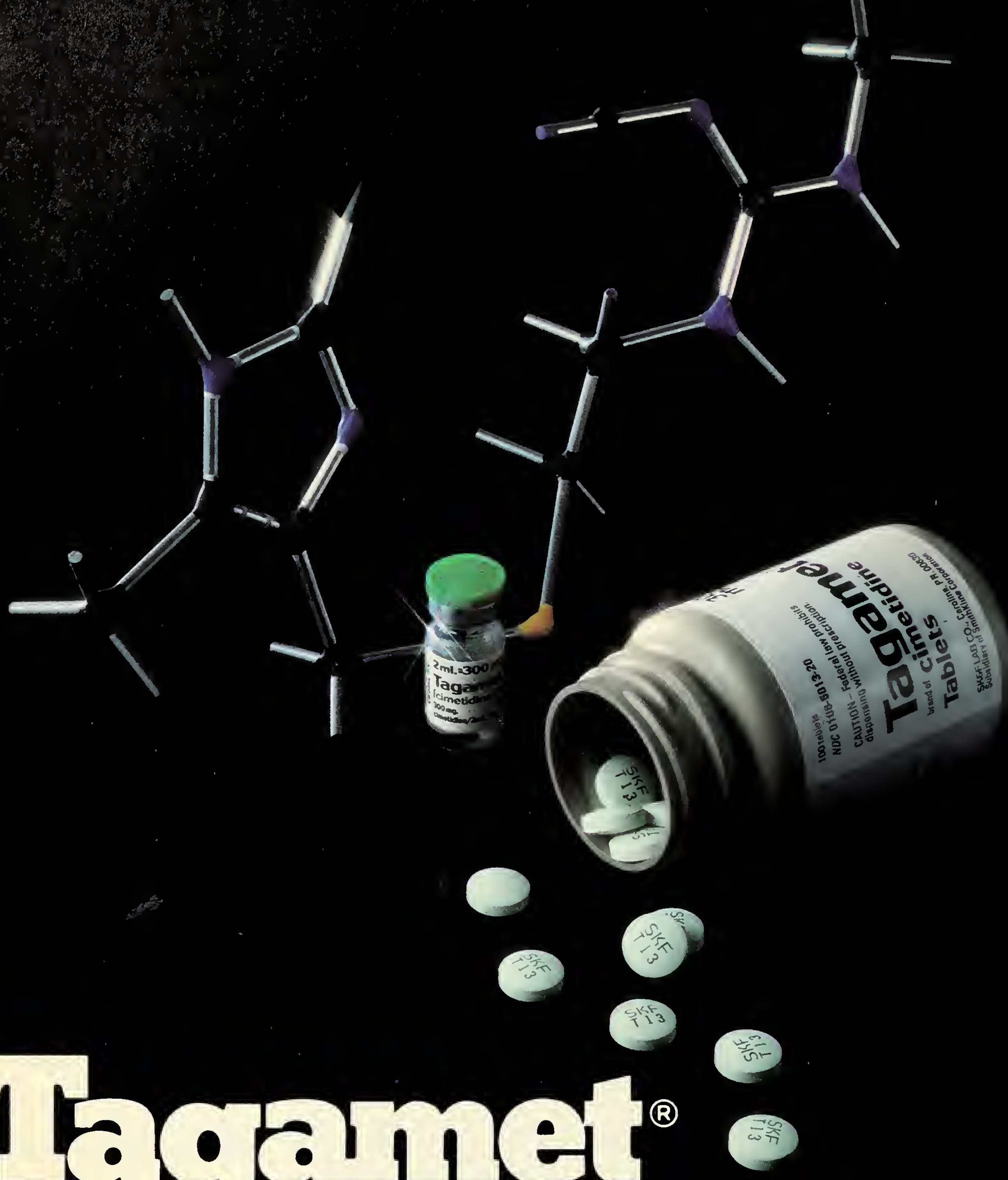
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News

By Katie Brewbaker, MSMS staff

George W. Morley, MD, is new interim chairman of the University of Michigan department of obstetrics and gynecology, in addition to continuing as chief of University Hospital's gynecology service and director of the department's gynecological oncology division.

William N. Hawks, Jr., MD, U-M clinical instructor in the department of ophthalmology, has spent a portion of the last two summers in the Aleutian Islands studying the eye pathology of the Aleuts and providing medical service. During his visits, Doctor Hawks has examined over 150 patients, ordering new glasses, fixing broken ones, treating general medical problems, and lecturing paramedical personnel in villages on numerous medical subjects. He traveled as part of an informal liaison between the Alaskan Native Medical Center and the U-M department of ophthalmology.

Michigan physicians contributed two articles to the October 13 issue of *JAMA*. **Alexander J. Walt, MD,** chairman, WSU Department of surgery, collaborated with five other physicians across the nation on a commentary entitled, "Hospital Care of the Trauma Patient." **Sheldon F. Markel, MD,** of Mercy Hospital's Department of Pathology, was a contributing author of "Prolonged Latent Schistosomiasis."

Doctors **Andre V. Jubert, Theodore Maycroft,** and **Timothy M. Talbott** published an article entitled, "Characteristics of Adenocarcinomas of the Colorectum with Low Levels of Preoperative Plasma Carcinoembryonic Antigen (CEA)" in the August issue of *Cancer*.

Hamilton O. Smith, MD, one of the recipients of the 1978 Nobel Prize in medicine, learned microbial genetics at the University of Michigan and may be remembered by many Michigan physicians. Doctor Smith served as a post-doctoral fellow and later research associate in the U-M department of human genetics from 1962-67. During that period, Doctor Smith studied and researched in the highly specialized field of bacteriophage genetics in the laboratories of Myron Levine, PhD, professor of human genetics.

Richard D. Hackley, MD, Flint, has been named president of the medical staff at St. Joseph Hospital. Prior to this appointment, Doctor Hackley served as chairman of the infection control committee and chaired the hospital's family practice department for two years.

Doctor Morley

Doctor Bowman

Doctor Papp

Doctor Hawks

John P. Papp, MD, Grand Rapids, has been elected for a two-year term as Councilor to the American Society for Gastrointestinal Endoscopy.

Appointed head of Henry Ford Hospital's new Division of Trauma and Emergency Surgery is **Robert S. Brown, MD,** an intensive care specialist and former army surgeon in Vietnam.

John F. Engstrom, MD, is acting director of alcoholism services at Hurley Medical Center in Flint. Doctor Engstrom previously served as medical director of an alcoholism therapy program at Bethany Medical Center in Kansas.

Newly elected president of the board of directors of the American Cancer Society's Berrien County Unit is **Demetrio M. Hechanova, MD,** a family physician from Berrien Springs.

Herbert E. Hamel, MD, has been chosen Citizen of the Year by the St. Ignace Chamber of Commerce. Doctor Hamel, who has practiced in the St. Ignace area for 31 years, was recognized for his work in scouting, the Chamber of Commerce, fire department, Red Cross, Kiwanis, and other community social activities.

St. Joseph physician **Thomas O. Miyata, MD,** has been appointed to represent Berrien County on the Southwest Michigan Systems board of directors. SWM Systems is a nonprofit corporation designated to implement an EMS system in eight southwestern Michigan counties.

Harold E. Bowman, MD, Grand Rapids pathologist, was re-elected to serve as a Michigan delegate-director to the American Cancer Society House of Delegates. Doctor Bowman is director of laboratories at St. Mary's, Ferguson-Droste-Ferguson, and Mary Free Bed hospitals in Grand Rapids.

Auxilians have strong commitment to AMA's Educational Research Fund

By Anita Yannitelli
MSMS-A Communications Chairman

As physicians' spouses, Auxilians are vitally interested in the future of medicine in this country and the betterment of medical education.

The American Medical Association Educational Research Foundation (AMA-ERF), is engaged primarily in supporting medical education; providing financial assistance to medical students, interns and residents; fostering scientific and medical research; and providing funds for rural and community-oriented pilot health projects.

"There has long been a strong commitment by auxiliary members to AMA-ERF," according to Mrs. Leland Brown, state chairman and Mrs. Henry Winkler, state vice-chairman. They coordinate activities throughout county auxiliaries with state and national programs.

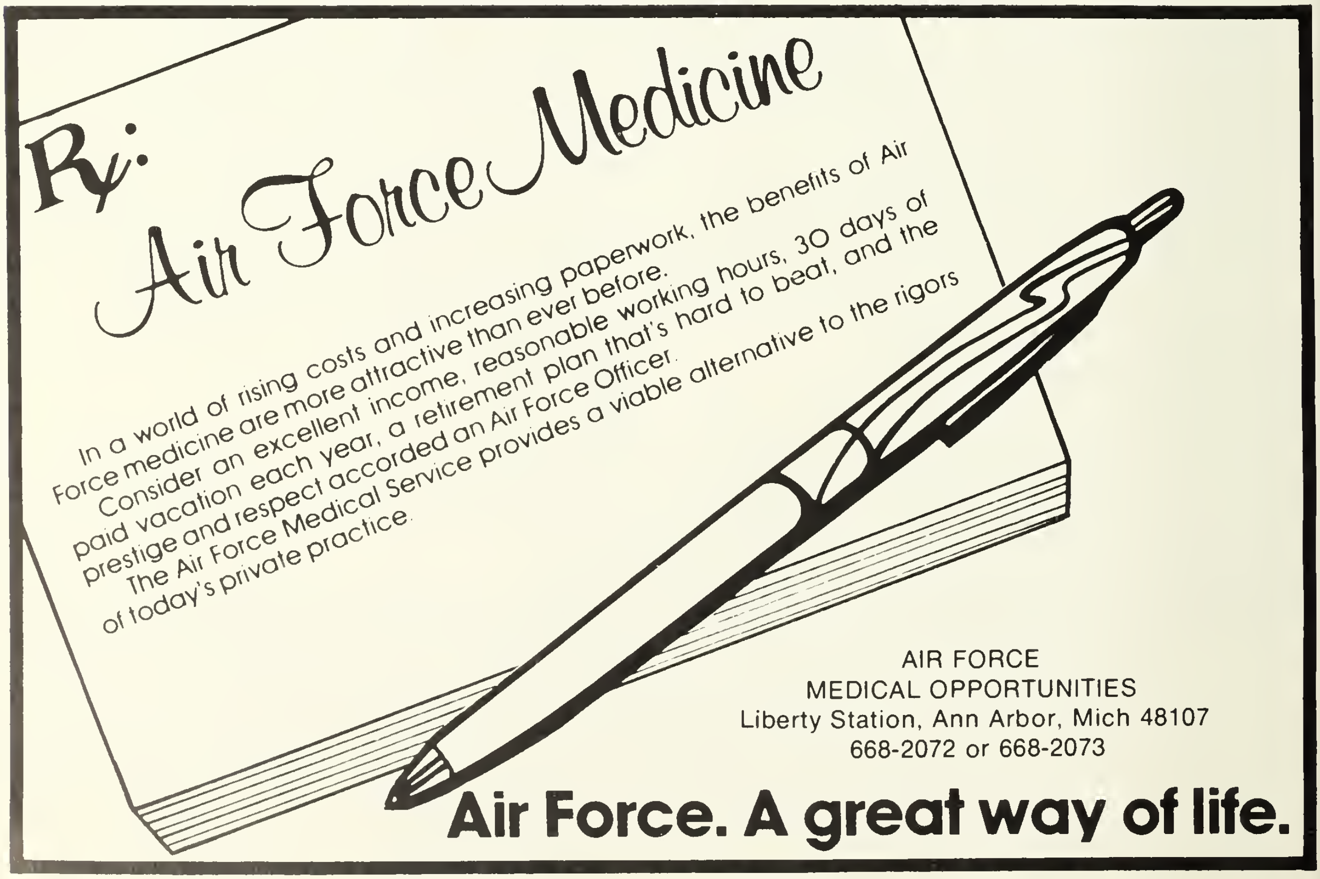
Need to increase

The need for AMA-ERF funding is expected to increase drastically in the future, James H. Sammons, MD, executive vice-president of AMA told auxiliary members attending the AMA-A leadership conference in Chicago recently.

(Continued page 686)

AMAZING
THE
HERB-ANIMAL

Mrs. Henry Winkler, left, displays "the amazing herb-animal," one of the items sold by MSMS Auxiliary members to raise funds for the AMA Educational Research Fund. The herb-animals were prominently on display at the MSMS Annual Scientific Meeting in November.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MSMS/A/*Continued*

"Department of Health, Education and Welfare Secretary Joe Califano contends there are too many doctors and has plans to decrease medical classes," he said. "This administration (Carter's) is also dedicated to closing the doors to foreign medical doctors."

Auxilians are particularly interested in achieving new records of contributions this year as John J. Coury, MD, a former MSMS president, is now serving as vice-president of AMA-ERF at the national level.

Last year's contribution of $34,000 by the MSMS Auxiliary (topped by only four other state auxiliaries), was part of more than $900,000 contributed to AMA-ERF by auxiliaries nationwide. Michigan's Macomb County auxiliary has been recognized repeatedly as one of AMA-ERF's top contributors. More than $8,000 was their total last year and, as a beginning this year, members reaped $5,000 from an October auction of contributed items.

The Christmas Sharing Card (a Christmas card sent to each county medical society member), is used by many counties as a money-raising project. Since auxiliaries underwrite mailing and card costs, all the money goes to the AMA-ERF fund. Last year this project netted $15,000 in Michigan.

Donations raised many ways

Auctions and bazaars, cross country ski days and tennis parties are among the many other fund-raising methods used by Michigan auxiliaries. Jewelry and other Christmas cards, watches and pecans are among items sold to benefit the AMA-ERF.

Auxiliary members also promote donations to AMA-ERF to thank colleagues for professional courtesy or to honor physicians who have passed away. Appropriate cards for these purposes (supplied by the AMA-ERF's national office) are mailed to the recipient or family informing them of the contribution made in their name. Anyone wishing to utilize this thoughtful, constructive type of remembrance may contact the county auxiliary's AMA-ERF chairman.

Funds may be ear-marked for use by a specific university, according to Mrs. Brown.

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SEPTIC ABORTION

A. Definition

A Septic Abortion is a threatened, inevitable or incomplete abortion complicated by infection as manifested by significant temperature elevation and/or a grossly purulent discharge from the cervix.

B. Diagnosis

1. Temperature, pulse, and respiratory rates are elevated.
2. Blood pressure is normal with increased pulse pressure.
3. Abdominal examination may or may not show evidence of pelvic peritonitis with uterine enlargement.
4. Pelvic examination findings may vary. The cervix may be dilated and exude a bloody, purulent discharge, or may be closed with a scant discharge, clearly purulent only on microscopic examination.
5. The following determinations should be done:
    a. Repeated vital signs
    b. Complete blood count and coagulation profile.
    c. Urinalysis (Indwelling catheter should be used for recording urinary output)
    d. Aerobic and anaerobic cultures of cervix
    e. Direct smear and gram stain from the endocervix
    f. X-ray of the abdomen for foreign bodies and the presence of free gas.

C. Management

1. Parenteral antibiotic therapy providing coverage against gram positive and gram negative aerobic and anaerobic organisms. Current recommendations would include:
    a. Aqueous procaine penicillin, 90 million units per 24 hours, intravenously, or with penicillin allergy, cephalothin 1-2 grams intravenously, every 6 hours
    b. Gentamycin, 5 mg/k/day, maximum of 240 mg/day, in three divided doses
    c. (Clindamycin, 600 mg intravenously every 6 hours or chloramphenacol, 50 mg/k/day in four divided doses intravenously if severe or unresponsive case) Toxicity of these drugs (clindamycin and chloramphenacol) should be considered.

    Daily CBC, reticulocyte count, and serum creatinine measurements are important means of monitoring possible bone marrow and renal effects of medications. Clindamycin should be discontinued with the appearance of significant diarrhea.
2. Uterine curettage should be performed as soon as adequate antibiotic coverage has been attained.
3. Adequate supportive measures consisting of fluid, electrolyte, and blood administration should be employed.
4. Administration of Rh₀ (D) immune globulin (RhoGAM), when appropriate, is recommended.
5. The use of oxytocics in selected cases may be beneficial.

SEPTIC ABORTION WITH ENDOTOXIC SHOCK

A. Definition

The coexistence of septic abortion as earlier defined and shock in the absence of evidence of excessive blood loss.

B. Etiology

Shock results from the direct effect on the intracellular body compartment of bacterial endotoxins from gram positive or gram negative organisms. Multiple organisms may be involved and the syndrome may be combined with hypovolemia due to blood loss.

C. Pathogenesis

Endotoxin generates cell destruction and death. An individual exposed to a massive dose of endotoxin is destined to succumb independent of the therapy applied. In a patient exposed to a smaller dose with prompt treatment, the same therapy may clearly be of value.

The major pathophysiologic elements consist of the following:

1. Vascular pooling, especially in the mesenteric circuits, with resultant decreased cardiac output and decreased tissue perfusion.
2. Pulmonary venular constriction rendering the patient sensitive to the risk of pulmonary edema from excessive intravenous fluid administration.
3. Sensitization of baroreceptors to arterial pressure stimuli resulting in increased sympathetic activity.
4. Subsequent apparently dose-related decrease in central sympathetic activity with loss of the enhanced adrenal secretion and vasodilation characteristic of item 3.

D. Management

1. The diagnostic and therapeutic measures described for septic abortion should be performed.
2. A Central Venous Pressure (CVP) catheter should be inserted in the superior vena cava or the right atrium and its position confirmed.
    a. If CVP is normal (6-12 cm of water), the patient is functionally normovolemic and intravenous fluid should be given with care.
    b. If CVP is elevated (greater than 12 cm of water), the patient is at risk of cardiac failure.
    c. If CVP is low (less than 6 cm of water), give 500 ml of electrolyte solution per 30 minutes, measuring CVP after each 100 ml infused. When CVP rises, use caution in subsequent intravenous fluid administration.
3. The following chemical determinations constitute a useful baseline:
    a. BUN, creatinine
    b. Serum Na, K, Cl, CO_2
    c. Blood pH, blood gases
    d. Blood and urine held for toxicology.

E. Therapy

1. Primary
    a. Use antibiotic and supportive therapy as described previously.
    b. Evacuate the uterus after initiating supportive therapy. Use uterine evacuation, preferably by suction, unless the process is extended beyond the myometrium, in which case hysterectomy is needed. While uncommon, clostridial infection may necessitate hysterectomy.
2. Supportive
    a. Replace volume with blood, plasma, or electrolytes sufficient to maintain normal venous pressure.
    b. Adrenocorticoids appear to decrease cellular damage by endotoxin. Give a large initial dose (methylprednisolone 2 gm, hydrocortisone 8 gm, or prednisone 2 gm) and maintain intermittent therapy at intervals of 2-4 hours.

This Card prepared by Thomas Kirschbaum, MD. *(9-78)*

Category I courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Jan. 18-20, Rheumatology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Rheumatologists, internists, family physicians. **Cost:** $150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 18 hours of Category I Credit.

Date: Jan. 24, Lymphoma Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Jan. 28-Feb. 2, Fourth Annual Seminar, "Emergencies in Medicine." Location: Boyne Highlands, Harbor Springs. **Sponsor:** Michigan Committee on Trauma, Michigan Society of Critical Care Medicine. **Cost:** $40. **Contact:** Robert F. Wilson, MD, or Theresa Sokol, WSU, Dept. of Surgery, School of Medicine, 540 East Canfield Ave., Detroit, 48201. **Approved for:** 23 hours of Category I Credit.

Date: Feb. 4-9, Family Practice Update. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: Feb. 10, Hematopathology. Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 15, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 19-23, Emergency Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians, internists, emergency physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 35 hours of Category I Credit.

Date: Feb. 27-28, Topics in Psychosomatic and Behavioral Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, primary care physicians. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Feb. 28-March 1, Michigan Conference on Maternal and Perinatal Health. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Herb Auer, MSMS, 517/337-1351. **Approved for:** 14 hours of Category I Credit.

Date: March 6-9, Hematology Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Hematologists. **Cost:** $225. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: March 14, Kidney Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: March 14-16, Advances in Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE: **For:** Pediatricians. **Cost:** $180. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: March 21, Early Breast Cancer. Location: Kalamazoo Center Inn, Kalamazoo. **Sponsor:** Bronson and Borgess Hospitals Oncology Section. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All Interested Physicians. **Cost** $50. **Contact:** Leo Zelkowitz, MD, Bronson Hospital, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: March 22-23, General Surgery. Location: Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education, Dept. of PGM/HPE. **For:** Surgeons. **Cost:** $140. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: March 24, A Day of Clinical Gastroenterology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **For:** Family physicians, internists. **Cost:** $70. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: April 2-27, Surgical Anatomical Review. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **For:** Surgeons. **Cost:** $425. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 120 hours of Category I Credit.

Date: April 12, Conference on Medical Aspects of Sports. Location: Towsley Center, Ann Arbor. **Sponsor:** MSMS. **Contact:** Herb Auer, MSMS, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 16-20, Family Practice Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME. 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: April 16-June 18, Pediatric Seminar IV. Location: St. John Hospital Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $200. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 20 hours of Category I Credit.

Date: April 24, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: May 10-11, Ophthalmology Conference. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists. **Cost:** $140. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: May 14-18, Head and Neck Oncology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otorhinolaryngologists, surgeons. **Cost:** $500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: May 21-25, Advances in Internal Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Internists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: June 7-8, Blood Banking. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $90. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Michigan physicians may write MSMS, 120 W. Saginaw St., East Lansing, 48823 for meetings of later dates.

Board of Medicine goal to shape complete guidelines of patient care

By Charles Downs
Special to **Michigan Medicine**

(This is the third of a three-part series examining the role of the Board of Medicine and its relevance to all Michigan physicians.)

"We don't make the laws; we only enforce them," says John R. Wilson, MD, president of the Michigan Board of Medicine (formerly the Medical Practice Board).

But, he also points out, the Medical Practice Act gives the board the duty of formulating some of the rules by which the law is administered. And that responsibility, he notes, is at once the hardest and potentially the most rewarding challenge facing the board.

"I think we have a potential — more than any single group of which I am aware — to upgrade the practice of medicine in Michigan," maintains the Grand Rapids pediatrician. "But we must be reasonable, sensible and do things in consultation with organized medicine."

The Medical Practice Act of 1973 and this year's revision of it have provisions that govern minimal standards of medical care. The board's job is to define those standards.

Such standards have never been defined before and even now it is a matter of slowly evolving them in collaboration with the Michigan medical community, says Doctor Wilson.

"If we can establish minimal standards at a reasonable rate — a reasonable level — we will improve the practice of medicine and give significant guidelines to all physicians. But we can't do it off-the-cuff. It takes a lot of thought."

The evolution of a set of standards, Doctor Wilson explains, takes place whenever the board elects to issue a formal complaint that a physician did not meet minimal standards in a particular instance.

Then, during the course of the compliance conference and the formal hearing, the decision to issue the complaint is thoroughly tested as arguments and expert testimony, pro and con, are presented.

Eventually, the net result of such cases, Doctor Wilson anticipates, will be a review of all of the decisions of the board and their translation into a formal code. But such an endeavor is still some years off.

However, he points out, a start has been made in the area of drug abuse through formulation of a set of rules for physicians to follow in respect to giving and prescribing amphetamines, the controlled drug that is most commonly diverted to illegal markets.

These rules have been published in *Michigan Medicine* and copies have been sent to every licensed physician in the state. The rules cover when amphetamines should be prescribed, the dosage, the amounts and other details.

The president of the board stresses that physicians throughout the state were given opportunities to contribute to the amphetamine guidelines.

The rules were published in draft form and public hearings were held at which anyone could comment. Physicians were specifically encouraged to comment at the hearings or in writing to the board. The rules also were submitted to the attorney general for legality and to the Legislature's Joint Rules Committee for its approval. The whole process took many months.

Overall, the effort of study, drafting and review took four years. Nevertheless, as Doctor Wilson points out, many physicians apparently did not learn of the rules until after they became effective.

"At least that is when we started to get some strong negative feedback," says Doctor Wilson. "We have been told that we are nothing but bureaucrats, even though we (10 of the 13 board members) are practicing physicians and had consulted with other physicians on this problem for four years.

"But I think we have come up with good, sensible rules for amphetamines. Sure, they may hurt less careful doctors; but when you compare our guidelines with those of other states, I think you will find ours are less rigid and more realistic."

"Moreover, we have made a good start toward a more complete set of guidelines defining minimal standards of medical patient care and that will be the most rewarding task of the board in years to come."

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—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

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Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

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There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

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Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

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PHYSICIANS, $47,982-$58,339 range, Michigan Department of Public Health to staff state positions as epidemiologists in communicable and chronic diseases and environmental chemical contaminants: Positions are: *Communicable disease clinician*, heavy emphasis on public health laboratory to epidemiologic problems, clinical trials of vaccines and other biologics; *environmental epidemiologist* to provide medical epidemiologic leadership to program to handle environmental chemical problems; communicable disease *epidemiologist* to provide surveillance and handle communicable disease problems. Michigan licensure and eligibility for or certification in medical specialty or public health + three years experience or equivalent. Civil Service position, excellent fringe benefits, equal opportunity. Send resume: Kenneth R. Wilcox, Jr., MD, P.O. Box 30035, Lansing, MI 48909. Phone: 517/373-1383.

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INTERNIST — interested in group practice with teaching responsibility. Send resume to Wilmer Rutt, MD, Ford Hospital-Fairlane Center, 19401 Hubbard Drive, Dearborn, MI 48126.

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WANTED: INDUSTRIAL PHYSICIAN full or part time, large industrial corporation, salary competitive, malpractice insurance, excellent employee benefits, including life insurance, hospitalization, major medical insurance, accident-sickness insurance, long-term disability, dental insurance, liberal vacation and retirement programs, stock investment plan, CME time. Send curriculum vitae and references to P.O. Box 29834, Detroit, MI 48229.

OCCUPATIONAL PHYSICIAN — For large multi-specialty group in beautiful Milwaukee, WI area — new facility of long established clinic. Office space and all equipment supplied by group. Pre-employment exams, diagnostic evaluations, on-the-job injuries for more than 300 Milwaukee area plants. Challenging position with great future for advancement. Excellent salary — many fine benefits including liberal profit sharing plan. Replies held in strictest confidence. Write Box 12, % MSMS.

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PHYSICIAN'S ASSISTANT — three years of primary care experience. Seeking employment in the Grand Rapids, Muskegon, Western Michigan area. Solo or group practice. Nationally certified. Write MSMS, Box 17, 120 W. Saginaw, East Lansing, 48823.

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—Dr. William Felts, Past President,
American Society of Internal Medicine

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**PATIENT CARE Magazine—Outlook 1977 "Face-Off. Cost Containment vs. Chaos," January 1, 1977.*

Lyle CB, et al. "Practice habits in a group of eight internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al. "Use of laboratory tests and pharmaceuticals: variation among physicians and effect of cost audit on subsequent use," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 225 (Aug. 20, 1973), 969-73.

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Deaths

Roy H. Baribeau, MD
Battle Creek

Roy H. Baribeau, MD, 88, of Battle Creek, died Oct. 17. Doctor Baribeau was a University of Michigan Medical School graduate. He was appointed by the U.S. government to serve as physician to workers constructing old Camp Custer. He was affiliated with Community and Leila Y. Post Montgomery hospitals, Battle Creek as well as Battle Creek Health Center.

Henry G. Chall, MD
Detroit

Henry G. Chall, MD, Detroit, died Oct. 11 at the age of 79. A general practitioner, Doctor Chall was a graduate of the Wayne State University School of Medicine. He was regional chairman of the Mental Health Committee of the American Academy of General Practice, was secretary of the General Practice Section at Grace Hospital, and was a member of Committee on Post Graduate Education in Psychiatry for Physicians other than Psychiatrists, of the Michigan Society of Neurology and Psychiatry.

James R. Doty, MD
Lapeer

James R. Doty, MD, 66, a Lapeer ophthalmologist, died Oct. 4. A graduate of the Wayne State University School of Medicine, Doctor Doty was chief of staff of Lapeer County General Hospital. He was also chief of the otolaryngology department at Oakdale Center for Developmental Disabilities. He was health officer for the City of Lapeer, and a past president of Lapeer County Medical Society as well as past secretary-treasurer. Doctor Doty's specialty society memberships included the Michigan Triological Society and the Saginaw Valley Academy of Ophthalmology and Otolaryngology.

Charles H. Frantz, MD
Ocean Ridge, FL

Charles H. Frantz, MD, formerly of Grand Rapids, died Oct. 16 at 72 years of age. An orthopedic surgeon of international acclaim, Doctor Frantz was a graduate of the University of Michigan Medical School. He had been chief of staff at Blodgett Memorial Medical Center and Mary Free Bed Hospital and Rehabilitation Center. A pioneer in his work with crippled children and adult orthopedic patients, he devised and published a widely used classification for diagnosing children born with limb problems. He was instrumental in establishing the Juvenile Amputee Training Center at Mary Free Bed Hospital, now the Area Child Amputee Center. Doctor Frantz was sent to Europe by President Eisenhower to advise on methods of treating 5,000 German children born with Thalidomide deformities. He was a member of the faculty of Northwestern University Medical School, was past president of the Clinical Orthopedic Society and was a member of the National Academy of Orthopedic Surgeons. Other memberships included the American Orthopedic Association, the International Society of Orthopedics and Traumatology, and the American College of Surgeons.

Francis L. Granger, MD
West Branch

Francis L. Granger, MD, West Branch, died June 13 at the age of 72. A general surgeon, Doctor Granger was a Wayne State University School of Medicine graduate. He was affiliated with Saratoga General, Holy Cross and Cottage hospitals. He was a District Senior Representative of the Wayne County Medical Society.

Lois A. Harrison, MD
Jackson

Lois A. Harrison, MD, Jackson, died Sept. 24 at 47 years of age. A graduate of the University of Michigan Medical School, Doctor Harrison was on the staff of Foote East and Foote West hospitals. She was a member of the American Academy of Family Physicians.

Allison B. Henderson, MD
Detroit

Allison B. Henderson, MD, Detroit, died Sept. 30 at the age of 66. Doctor Henderson was a graduate of Meharry Medical College, Tennessee. He was a consultant at Detroit General, Wayne County General and Kirwood hospitals. An internal medicine specialist, Doctor Henderson had done extensive research into sickle cell anemia. He was a member of the American College of Physicians, vice-chairman of the medical section of the National Medical Association, and a vice-chairman of the American Cancer Society. He also was a clinical instructor in medicine at Wayne State University, and a member of the editorial board of the Journal of the National Medical Association. Doctor Henderson also was a director of World Medical Relief, Inc. His memberships in other societies included the New York Academy of Sciences, the American Heart Association, the American College of Angiology, the American Diabetic Association, and the Detroit Gastroenterological Society.

Sophie Mishelevich, MD
Warren

Sophie Mishelevich, MD, 84, of Warren, died Sept. 26. Born in Russia, Doctor Mishelevich was a psychiatrist on the staff of Doctor's Hospital, Detroit and Glen Eden Hospital, Warren. She was a member of the American Psychiatric Association.

William B. Scott, MD
Grand Rapids

William B. Scott, MD, Grand Rapids, died August 25 at 75 years of age. Doctor Scott was a graduate of Howard University College of Medicine, Washington, DC, and was affiliated with Blodgett Memorial and St. Mary's hospitals, Grand Rapids.

Thomas N. Wills, MD
Light House Point, Florida

Thomas N. Wills, MD, Light House Point, Florida, formerly of Genesee County, died Sept. 29 at the age of 79. Doctor Wills graduated from Queen's University, Ontario, Canada. He was affiliated with St. Joseph's, Hurley, and McLaren hospitals, Flint.

President's page

Administrators, planners, plotters and schemers

We must function constructively in current governmental intervention in health care delivery while we work for change or repeal of laws.

This issue of *Michigan Medicine* is devoted to presenting some facts about new laws affecting the organization and delivery of health care.

These laws have been enacted by our national or state legislators in their wisdom. As responsible citizens, we must function with the constraints of these laws. Enlightened self interest demands that we participate in the development and implementation of their required activities in the best interests of our patients as well as of our profession.

It becomes evident that to withdraw and adopt the attitude that these laws are wrong and that we should have nothing to do with them, as some of our colleagues advocate, is self-defeating and will make remediation of the defects in existent law and regulations more difficult.

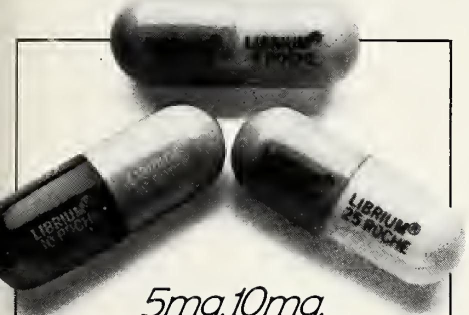
We must in good faith work with the existing mechanisms and make them as useful as we can. We have the dedication, the knowledge and the skills which are required to do this. Such action will not, however, prevent us from working for constructive modification and repeal of laws when such action is warranted. The laws will not just "go away" because we refuse to cooperate.

There are many in other health fields who think they can take over our responsibilities and do a better job than we. It is my belief that they act from ignorance, from envy and from ambition for status and pay. And there are others who think they should be given the chance even if it sets back our health care delivery mechanisms for 20 to 30 years.

We must work — and we have worked — with the system to share our insights and to modify the worst aspects of the new proposals. We have made constructive suggestions and we will continue to do so. We will lose some significant battles only to be proven right in our evaluations. We also will find that some of our fears and concerns were ill-founded and that there are some knowledge, awareness and new ideas about health care by people outside of medicine.

We also must develop our skill in recognizing sound administrative principles and sound planning. We must differentiate these from the plots and schemes which abound today under the genre of planning.

Louis E. Heideman, MD
MSMS president



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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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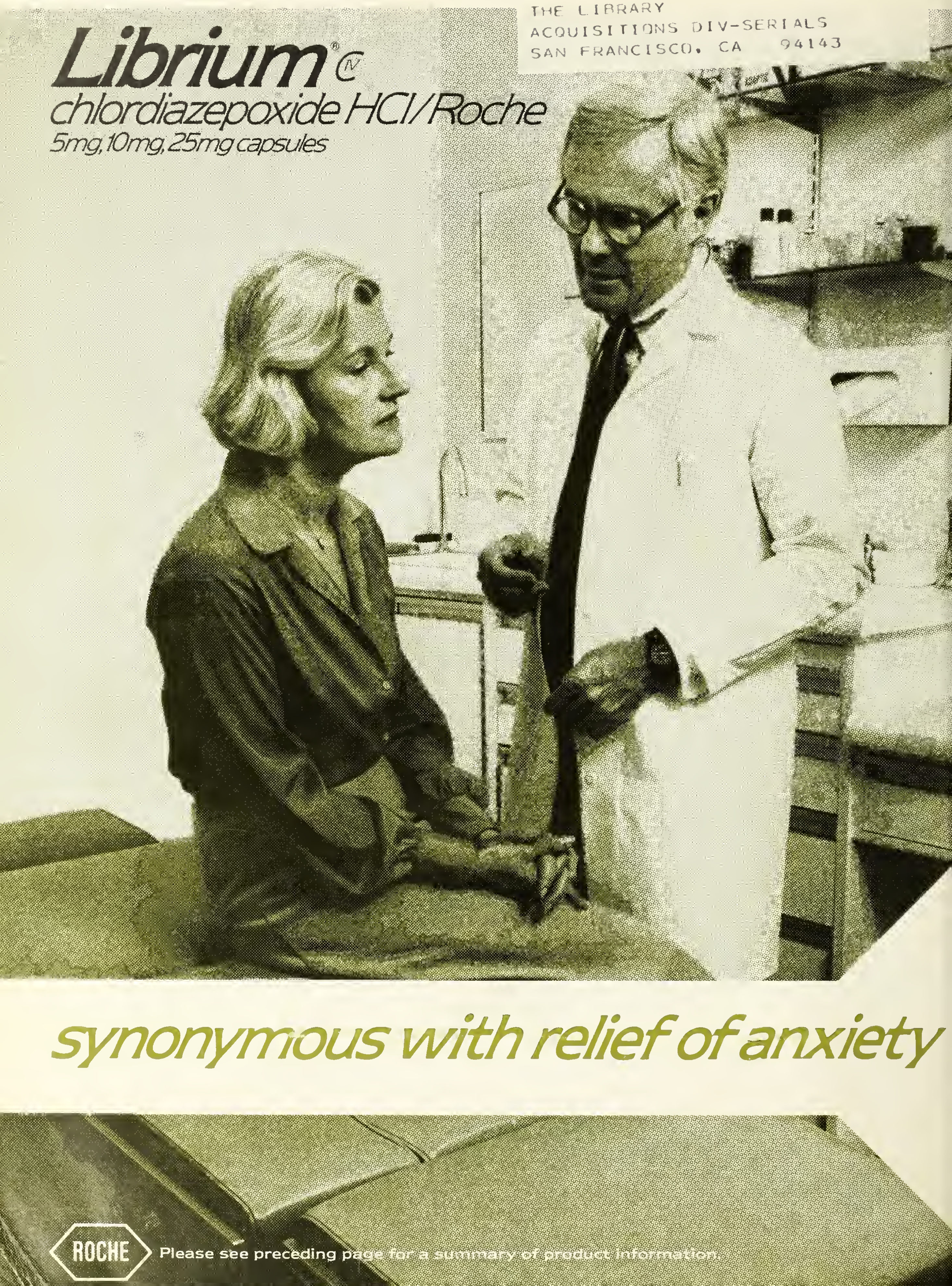

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APSULES

EMINDER: Dec. 31 is the deadine for Michigan physicians apply for relicensure. ctors must file three things th the Michigan Board of dicine: 1) their applicaion for relicensure, 2) eir report of earned coninuing medical education edits, and 3) their reliensure fee of $25. New CME les and regulations require ysicians to earn 150 hours CME credit in three years. r 1979 relicensure, physiians have to have earned 0 hours over the threeear period 1976-77-78.

* * *

Y MICHIGAN PHYSICIANS conidering computers for their fices should find a proposed w physician group an excelnt place to start. MSMS uncilor Marion G. McCall, , Detroit, is organizing a ecial Interest Group/Medine (SIG/MED) under the spices of the Southeastern chigan Computer Organization EMCO). "We propose the owing interest by physicians computers be channeled so can capture maximum physian input in system design d cost," says Doctor McCall. asks interested physicians contact him at 18242 Faireld, Detroit, 48221.

* * *

MPONENT AND SPECIALTY socity presidents, PR chairmen, ecutives and interested ysicians are invited to a b. 1 MSMS workshop on dealg with the news media. The eting, to be held at MSMS adquarters, will feature ofessional expertise and tual writing, interviewing d "on camera" sessions designed to impart skills necsary to work effectively th the media. Contact Mert holten, MSMS headquarters, r further details.

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
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MSMS Council highlights

On December 13, the MSMS Council:

1) Representing MSMS as the sole stockholder, approved the bylaws of the new MSMS for-profit corporation, the Physician Service Group, Inc. Also, a slate of seven persons was elected to serve as the Board of Directors of PSG, Inc. They are Brock Brush, MD, Detroit; James Dansforth, MD, Grosse Pointe Woods; Jay Harness, MD, Chelsea; Allen Turcke, MD, Flint; Wil E. Maldonado, MD, Lansing; Leland E. Holly II, MD, Muskegon; and Warren F. Tryloff, East Lansing.

2) Voted to establish a task force to investigate the problems of medical fraud and over-utilization and to consider alternative solutions.

3) Voted to appoint a Committee on Emergency Medicine to develop policies on emergency medicine for MSMS and to develop liaison with the Michigan Department of Public Health re the categorization of hospital emergency room projects.

4) Concurred with Committee on State Legislation and Regulations' recommendations to continue opposition to legislation designed to legalize or recognize legal use of Laetrile to oppose current medical rights of minors legislation while working with the bill's sponsor to identify how the medical needs of minors adequately can be met; to support extending the uniform anatomical gift act; and to restore subpoena powers to the Michigan Board of Medicine.

5) Heard a report of the current status of the Michigan medical arbitration system, and referred to the MSMS Committee on State Legislation and Regulations the system's policies of assessing various state groups for support.

6) Heard reports on current lawsuits involving chiropractors and the AMA, and received a progress report from Donald Crandall, MD re the MSMS Work Group meeting with the Blues.

CAPSULES/continued

MSMS MEMBERS MAY HURRY and claim a tax deduction for payment of their 1979 MSMS, AMA and county dues if they remit by Dec. 31. Response has been excellent to date in membership renewals. The totals are $190 for MSMS dues and $250 for AMA dues, while county dues vary.

* * *

PLANS FOR THE 1979 MSMS Annual Scientific Meeting are taking shape under the direction of the new chairman, Samuel McMahon, MD, East Lansing. Doctor McMahon succeeds three-time chairman Robert F. Wilson, MD, Detroit. The advisory committee to Doctor McMahon is to meet Dec. 21 at Howell Holiday Inn to review evaluations of 1978 courses. The advisory committee already has corresponded with specialty societies and deans and department chairmen of the state's medical schools to begin plans for the 1979 meeting.

Draft State Health Plan modified

MSMS and other health care groups have been working to modify controversial sections of the draft Statewide Health Plan expected to be approved as this issue went to press. The Statewide Health Coordinating Council was meeting Dec. 14 and 15 to adopt a much modified plan. Upon adoption by the SHCC, the preliminary statewide plan will be submitted to the legislature and governor for concurrence.

MSMS reactions to specific proposals and recommendations of the draft plan are detailed in the December issue of Michigan Medicine, for MSMS members' information.

Medicaid/abortion issue continues

At this writing, it appears newly-re-elected Gov. William Milliken will have to continue to separate 1979 Medicaid appropriations for physician, hospital and pharmaceutical services from attempts to prohibit Medicaid funding of abortions. MSMS has continued to work to have the two issues separated. As this Medigram was going to press, the legislature was working on a $520 million Medicaid budget for physician, hospital and pharmaceutical services. Both Senate and House were making it possible for the governor to separate the abortion funding ban from other Medicaid appropriations. The governor has said he will continue to veto any Medicaid appropriations with such a provision attached. The same entanglement caused the legislature to pass a supplemental appropriation for physician, hospital and pharmaceutical services in October which expires at the end of this month. If the two issues cannot be separated again, the entire medical services appropriations package again will be jeopardized.

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